REPORT TO THE CONGRESS

Lengthy Delays In Settling The Costs Of Health Services Furnished Under Medicare

B-164031(4)

Social Security Administration

Department of Health, Education, and Welfare

BY THE COMPTROLLER GENERAL OF THE UNITED STATES

JUNE 23, 1971

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

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To the President of the Senate and the
Speaker of the House of Representatives

This is our report on the lengthy delays in settling the costs of health services furnished under Medicare which is administered by the Social Security Administration, Department of Health, Education, and Welfare.

Our review was made pursuant to the Budget and Accounting Act, 1921 (31 U.S.C. 53), and the Accounting and Auditing Act of 1950 (31 U.S.C. 67).

Copies of this report are being sent to the Director, Office of Management and Budget, and to the Secretary of Health, Education, and Welfare.

Comptroller General
of the United States

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WHY THE REVIEW WAS MADE

Federal payments to institutions for health services provided to Medicare patients usually are made through fiscal intermediaries. These intermediaries serve under contracts made with the Department of Health, Education, and Welfare (HEW) and administered by the Social Security Administration (SSA).

For fiscal years 1967 through 1969, institutions were paid about $11 billion for their costs of furnishing services to Medicare patients. About $10 billion was paid to hospitals.

Payments to institutions are made initially on an estimated basis but are subject to adjustments at the end of the institutions' Medicare reporting periods, after the intermediaries have determined the institutions' actual and reasonable Medicare-related costs. This procedure culminates in a final settlement between the intermediary and the institution and is referred to as the settlement process.

The principal Medicare fiscal intermediary is the Blue Cross Association which has subcontracted its functions as intermediary to 74 individual Blue Cross Plans.

The General Accounting Office (GAO) made a review to find out the causes for lengthy delays in the settlement process and to suggest ways to minimize the delays. The 13 Blue Cross Plans included in the GAO review were located in 10 States and dealt with about 32 percent of the 6,800 hospitals participating in the Medicare program at September 30, 1970.

FINDINGS AND CONCLUSIONS

Because of the lengthy delays by fiscal intermediaries in completing the settlement process, billions of dollars of Medicare funds paid out on the basis of the estimated cost of services long since incurred have not been afforded an appropriate final accounting or a timely review by the intermediaries and the Federal Government.

At September 30, 1970, over 3 years after the end of the reporting periods for the first year under Medicare, final settlements for the

cost of care provided had been made with only 68 percent of the hospitals included in the GAO review. Furthermore, at that date, over 2 years after the end of the reporting periods for the second year under Medicare, final settlements for the cost of care provided had been made with only 38 percent of the hospitals included in the GAO review.

There were delays in every step of the settlement process, from the preparation of cost reports by hospitals, through the audit of cost reports by intermediaries, to the final settlement or agreement with hospitals concerning their actual and reasonable Medicare costs to be reimbursed under the program.

Intermediaries and hospitals attributed some of the delays to SSA's administration of the program.

--There have been problems with certain SSA-generated financial and statistical data (reimbursement report) intended to assist hospitals in preparing their Medicare cost reports and to guide intermediaries in making audits and final settlements. (See pp. 15 to 18.)

--Some intermediaries delayed making final settlements with hospitals because a method of apportioning hospital costs between Medicare and non-Medicare patients which was authorized by HEW resulted in Medicare payments that included certain private room costs, which were not covered under the program, and certain delivery room costs, which were not applicable to Medicare patients.

On the basis of an analysis of a sample of cost reports for hospitals in 32 States and Puerto Rico, GAO believes that the elimination of this questionable apportionment method (combination method) would reduce Medicare payments to hospitals by between $100 million and $200 million annually. (See pp. 19 to 32.)

Reasons for delays in the various steps in the settlement process are outlined in the following sections.

Delays in submission of cost reports

For the first year's reporting periods, only 7 percent of the hospitals submitted their reports within 90 days after the end of their reporting periods, as prescribed by SSA. On the average most of the remaining hospitals were about 4 months late. GAO did not note any improvement in the submission of second-year cost reports but did note some improvement in the submission of third-year cost reports. GAO noted that cost reports had been submitted late because of

--inadequacies in hospital accounting systems and insufficient numbers of hospital employees capable of preparing the reports (see pp. 42 to 44) and

--delays by public accounting firms employed by the hospitals in completing their audits before submission of the cost reports (see pp. 44 to 46).

Delays in initial reviews

Many intermediaries did not complete their initial reviews for periods of from 1 to 3 months because

--the cost reports were incorrect or incomplete and either were returned to the hospitals or were held by the intermediaries pending the receipt of additional information (see p. 52) or

--the intermediaries did not have sufficient staff to make the reviews, particularly at times of peak work loads (see pp. 53).

Delays in making field audits

For the first 3 years under the Medicare program, intermediaries scheduled for field audits virtually all the cost reports of the hospitals included in the GAO review.

--For some intermediaries that made field audits with their own staffs, delays in starting the audits were caused by an uneven audit work load because many hospitals serviced by an intermediary had the same reporting periods. (See pp. 61.)

--For some intermediaries that subcontracted the audit function, delays of from 3 to 6 months in starting the audits occurred because of difficulties in obtaining SSA approval of the audit subcontracts. (See pp. 62 to 64.)

Delays in making final settlements

After the field audits were completed, final settlements were delayed further because of disagreements between the intermediaries and the hospitals as to the proper amounts of Medicare-related costs.

GAO believes that there is a need for more direct involvement of the prime contractor (Blue Cross Association) in bringing about final settlements in those cases in which audits have been completed for some time. (See pp. 75 and 76.)

There have been similar delays in making settlements with extended-care facilities. These delays are especially significant because of the large number of extended-care facilities that have left the Medicare program without having made settlements with intermediaries. (See. pp. 77 to 80.)

Unless improvements in the several steps of the settlement process are made, the Medicare payments--amounting to billions of dollars--that have

not been afforded an appropriate final accounting can be expected to increase and reports to HEW and congressional bodies on Medicare reimbursements to institutions will not be based on the most current and accurate data.

RECOMMENDATIONS OR SUGGESTIONS

The Secretary of HEW should provide for SSA to take certain actions aimed at alleviating the unsatisfactory conditions revealed during the GAO review. (See pp. 32, 48, 56, and 75). GAO's recommendations include having SSA:

--Establish a definite timetable for the development of effective, useful, and timely reimbursement reports for use by hospitals and intermediaries in the settlement process or consider other alternatives, such as authorizing intermediaries to prepare the reports. (See p. 32.)

--Discontinue or modify the use of the combination method of apportioning hospital costs between Medicare and non-Medicare patients. (See p. 32.)

--Encourage hospitals to adopt different cost-reporting periods to provide a more even distribution of intermediaries' work loads and to facilitate the preparation and/or audit of cost reports by the hospitals' accounting firms. (See p. 48.)

--Require the Blue Cross Association to take a more active role in the final settlement process by directly assisting those local Blue Cross Plans that have the most serious backlogs of audited cost reports for which settlements have not been made. (See p. 75.)

AGENCY ACTIONS AND UNRESOLVED ISSUES

HEW agreed, in part, with some of GAO's recommendations and did not agree with others. Of particular significance is HEW's decision to discontinue the use of the combination method of apportioning hospital costs to the Medicare program for larger institutions (e.g., having 100 or more beds). HEW estimates that this action will reduce Medicare costs by $100 million in fiscal year 1972.

HEW's decision to discontinue the use of the combination method will require changes in the Code of Federal Regulations pertaining to Medicare. GAO believes that HEW should consider certain other factors before such changes in regulations are finalized. (See pp. 34 to 37.)

SSA intends to try to solve its problems in producing reliable and timely reimbursement reports for use in the settlement process rather

than to consider alternatives as recommended by GAO. GAO noted, however, that some of the specific actions cited by HEW to solve the problems had been attempted previously by SSA without solving the problems. (See pp. 33 and 34.)

To facilitate--through a more even distribution of work loads over the year--both the preparation of cost reports by the hospitals' accounting firms and the processing and auditing of cost reports by the intermediaries, SSA is considering a change in its instructions to require that Medicare cost reports cover the same reporting periods and have the same due dates as the hospitals' annual reports to the Internal Revenue Service. GAO believes that the SSA-proposed change has merit, particularly where it can be adapted to expedite the overall settlement process. (See pp. 49 and 50.)

HEW believes that the Blue Cross Association's role in the Medicare program is essentially an administrative rather than an operating one and that it does not have sufficient staff to become directly involved in individual hospital cost settlements.

GAO believes, however, that the role of the Blue Cross Association under its contract with HEW should be to require performance from its subcontractors (the local Blue Cross Plans) or to take such steps as may be necessary to fulfill its contractual obligations. Such steps could include assisting certain Plans in making settlements with individual hospitals, particularly where such settlements at a particular Plan had been consistently delayed for unduly long periods of time after audit. (See pp. 75 and 76.)

MATTERS FOR CONSIDERATION BY THE CONGRESS

During 1970 the cognizant legislative committees of the Congress considered HEW's proposal that institutions providing services to Medicare patients be paid on a prospective basis rather than on a retrospective, reasonable-cost basis.

The committees concluded that reimbursement on the basis of prospective rates should be authorized on an experimental basis only. The committees pointed out in their reports that a solid foundation of experience was required for all possible alternative forms of reimbursement before permanent changes were made. Although legislation authorizing the use of prospective rates on an experimental basis was not enacted by the Ninety-first Congress, similar legislation was introduced in January 1971 in the Ninety-second Congress.

This report is being sent to the Congress because of its interest in the problems which have occurred in the Medicare program relating to the reimbursement of costs incurred by the participating institutions.

Contents

ABBREVIATIONS

BCA	Blue Cross Association
ECF	Extended-care facility
GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare
SSA	Social Security Administration

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CHAPTER 1

FEATURES OF MEDICARE PROGRAM PERTINENT TO SETTLEMENT PROCESS

The Medicare program was established by the Social Security Amendments of 1965 (42 U.S.C. 1395-1395 11). This program, which became effective on July 1, 1966, is administered by the Social Security Administration, Department of Health, Education, and Welfare and provides two basic forms of protection against the costs of health care for eligible persons aged 65 and over.

One form, designated as Hospital Insurance Benefits for the Aged (part A), which is the principal subject of this report, covers inpatient hospital services and post-hospital care in extended-care facilities (ECFs) and in the patients' homes. Part A is financed primarily by special social security taxes collected from employees, employers, and self-employed persons. These taxes are deposited in the Federal hospital insurance trust fund.

The second form of protection, designated as Supplementary Medical Insurance Benefits for the Aged (part B), is a voluntary program and covers physicians' services and a number of other medical and health benefits, including hospital outpatient services and certain home care. Part B is financed, in part, from premiums collected from each eligible beneficiary who has elected to be covered by the program. The premiums, which are deposited in the Federal supplementary medical insurance trust fund, are matched by equal amounts appropriated from the general revenues of the Federal Government.

As of June 30, 1969, over 20 million people had part A coverage. From July 1, 1966, through June 30, 1969, part A benefit payments, which are subject to the settlement process discussed in this report, amounted to almost $11 billion. Additional costs of about $283 million were incurred in administering part A. The benefit payments and related administrative costs paid under Medicare are summarized in the following table.

	Fiscal year			
	1967	1968	1969	Total
	(000,000 omitted)			
Benefit payments:				
Hospitals	$2,394	$3,389	$4,221	$10,004
ECFs	102	317	390	809
Home health agencies	12	30	43	85
Total	2,508	3,736	4,654	10,898
Administrative costs	74	97	112	283
Total	$2,582	$3,833	$4,766	$11,181

During the same 3-year period, part B benefits of about $155 million, which are also subject to the settlement process, were paid to providers for certain outpatient hospital services and for home care.

USE OF INTERMEDIARIES TO ADMINISTER PART A

Section 1816(a) of the Social Security Act authorized the Secretary of HEW to enter into agreements with public and private organizations and agencies which had been nominated by the providers to act as fiscal intermediaries in the administration of benefits under part A.

Among other things these fiscal intermediaries are responsible for (1) making payments at least monthly on an estimated basis to providers for covered services furnished to Medicare beneficiaries, (2) furnishing consultative services to assist providers in developing accounting and cost-finding procedures which will ensure that providers receive equitable payment under the program, (3) communicating to providers any information or instructions furnished by the Secretary of HEW and serving as a channel of communication from providers to the Secretary, (4) making such audits of the records of the providers as may be necessary, and (5) making final annual determinations, on the basis of such audits, of the amounts of payments to be made.

The intermediaries' costs for performing these functions under their contracts with the Secretary--which amounted to about $164 million for fiscal years 1967 through 1969--are reimbursed from the hospital insurance trust fund.

SELECTION OF BLUE CROSS ASSOCIATION AS AN INTERMEDIARY

In November 1965 the American Hospital Association nominated the Blue Cross Association (BCA) to serve as an intermediary, and in January 1966 the Secretary of HEW announced the selection of BCA for this role. In June 1966 SSA, under a delegation of authority from the Secretary, entered into a contract with BCA which, in turn, entered into subcontracts with 74 individual Blue Cross Plans for the performance of most of the intermediary functions set forth in BCA's agreement with SSA.

In September 1970 BCA was acting as intermediary for (1) about 90 percent of the 6,800 hospitals and (2) about 60 percent of the 6,900 ECFs and home health agencies participating in the Medicare program at that time. The remaining participating institutions deal either directly with SSA or with nine other private organizations serving as intermediaries.

Our review was made at the SSA Central Office in Baltimore, Maryland; at the Blue Cross Association in Chicago, Illinois; and at 13 Blue Cross Plans. These Plans, located in 10 States, were responsible for making about 35 percent of the benefit payments made during fiscal years 1967 through 1969. These 13 Plans were also responsible for making about 2,245 first-year (1967) hospital settlements and about 2,325 second-year and third-year (1968 and 1969) hospital settlements.

METHOD OF PAYMENT TO PROVIDERS OF SERVICE

According to section 1814(b) of the Social Security Act, payments to providers of service are to be made for the reasonable cost of services furnished to Medicare beneficiaries as determined under section 1861(v) of the same law. Section 1861(v) authorizes the Secretary of HEW to prescribe regulations establishing the method or methods to be used in determining reasonable costs and states that such regulations should provide for making suitable retroactive corrective adjustments where, for a provider of services for any accounting period, the aggregate reimbursement proves to be either inadequate or excessive.

In implementing these requirements, SSA issued regulations entitled "Principles of Reimbursement for Provider Costs," which established the guidelines and procedures to be used by providers of service and fiscal intermediaries in determining reasonable cost. It was intended by SSA that these reimbursement principles would result in giving recognition to all necessary and proper costs incurred by providers in furnishing services to Medicare patients and would avoid the inclusion of the costs of providing care to non-Medicare patients.

Providers of service are paid on an estimated basis during the year. These interim estimated payments are intended to approximate, as nearly as possible, actual costs in order to minimize the amounts of adjustments at the time of final settlement.

To facilitate making final settlements, providers are required by SSA instructions to submit to intermediaries annual Medicare cost reports covering a 12-month period of operations. During the first year of the program, a provider had the option of submitting a report covering the period July 1, 1966, to the end of its accounting year if such report covered at least 6 months.

A provider may select any 12-month period for Medicare cost-reporting purposes regardless of the reporting year it otherwise uses. According to SSA instructions, cost reports are required to be submitted to the intermediary within 90 days after the end of the provider's reporting period.[1]

Preparation of Medicare cost reports

The principal document used in the settlement process is the Medicare cost report. This report was developed by

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[1] In August 1970 SSA extended the due dates for the submission of cost reports to 120 days after the close of the hospitals' reporting periods for those hospitals that elected to submit Medicare cost reports which had been certified as accurate by the hospitals' independent auditors.

SSA in consultation with provider and intermediary groups and was designed to show what portion of a provider's total allowable costs was applicable to covered services provided to Medicare beneficiaries.

Although the SSA principles of reimbursement offer a provider several alternatives in arriving at the amount to be reimbursed, the preparation of a cost report essentially consists of the following four steps.

1. Determination of allowable costs

Under the SSA principles of reimbursement, direct and indirect costs which are reasonable and necessary for providing patient care are allowable. Certain specific costs, however, are unallowable and must be excluded for reimbursement purposes. These unallowable costs include (a) amounts attributable to physicians' care to individual patients, which are reimbursable under part B, (b) bad debts applicable to non-Medicare patients, (c) fund-raising expenses, (d) costs of activities unrelated to patient care, such as cafeterias and gift shops, and (e) costs of personal convenience items, such as telephone, radio, and television services.

2. Allocation of allowable costs to revenue-producing activities

After a provider has determined its total allowable costs for Medicare reimbursement purposes, the second step is to allocate these costs to those activities or services for which the hospital makes charges. This process, which is commonly referred to as cost finding, involves the allocation of the costs of non-revenue-producing activities or departments (such as administration, laundry, and housekeeping) to revenue-producing activities or departments (such as operating rooms, pharmacies, laboratories, and routine daily services).

3. Apportionment of allowable costs between Medicare and non-Medicare patients

After the provider has allocated its allowable costs to its revenue-producing activities, the third step is to

apportion these costs to the Medicare program on the basis of charges applicable to Medicare patients. For example, if 40 percent of the charges of a hospital's X-ray department were applicable to X-ray services provided to Medicare beneficiaries, 40 percent of the allowable costs allocated to the X-ray department would be apportioned to the Medicare program for reimbursement purposes.

Although the SSA principles of reimbursement offer a number of alternatives in making such apportionments, the use of charges as the basis for apportioning costs represents a principal feature of the reimbursement method under the Medicare program.

4. Consideration of amounts paid by the beneficiaries and interim payments made by the intermediary

After the provider has apportioned its allowable costs to the Medicare program, it must consider the deductible and coinsurance amounts payable by the Medicare patients[1] and the interim payments due from the intermediary for the services provided to Medicare patients during the provider's reporting period. The difference between the allowable costs and the sum of payments received or due from the patients and the intermediary represents the amount of the final adjustment due to or from the program.

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[1]As of January 1, 1971, the amounts payable by the Medicare beneficiary for inpatient hospital services were $60 for the first 60 days of hospitalization, $15 a day for the 61st day to the 90th day of hospitalization, and $30 a day for the 91st day to the 150th day of hospitalization in the event that the beneficiary elected to use his 60-day lifetime reserve of hospital benefits. In addition, the beneficiary is responsible for the cost of the first three pints of blood. As of January 1, 1971, the amounts payable by the beneficiary for services provided in an extended-care facility were $7.50 a day for the 21st day through the 100th day.

Steps in settlement process

Although actual procedures followed by Blue Cross Plans varied during the first three reporting periods under Medicare, the process of making final settlements with providers dealing with BCA usually consisted of the following four steps.

1. Submission of cost reports

SSA instructions require that, within 90 days[1] after the end of a provider's reporting period, a completed cost report be filed with the intermediary. These instructions also authorize intermediaries to grant time extensions if providers are unable to complete and submit their cost reports within the 90-day period.

2. Desk audits and tentative settlements

Upon receipt of the cost report, the intermediary is responsible for making a "desk audit" to check the completeness of the cost report and to identify any obvious errors or inconsistencies. On the basis of the desk audit, the intermediary may then make an initial retroactive adjustment, or tentative settlement, with the provider. SSA regulations provide that, for the purpose of making tentative settlements, costs be accepted as reported by the provider unless obvious errors and inconsistencies are noted.

3. Performance of field audits

All cost reports are subject to field audits which consist of an onsite examination by the intermediary of the provider's accounting records and related statistical

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data. For the first three reporting periods under the Medicare program (providers' reporting periods ended on or before June 30, 1967, 1968, and 1969), such field audits were scheduled for virtually all cost reports.

Although field audits sometimes were undertaken by the intermediaries' staffs, the audits usually were made by public accounting firms under subcontracts with the intermediaries. Under the terms of the standard subcontract prescribed by SSA, the public accounting firm agreed to complete its audit of the provider's cost report, make any necessary adjustments, and render an opinion as to the accuracy of the report within 90 days after the intermediary had forwarded the cost report to the firm unless the intermediary agreed that it was necessary to extend this time limit.

4. Final settlements

After the field audit has been completed and audit adjustments have been agreed to by the providers, the Blue Cross Plan can make a final settlement with the provider. Blue Cross Plans operate under subcontracts with BCA, and their determinations of the reasonable costs to be reimbursed are subject to review and concurrence by BCA.

Although the 13 Blue Cross Plans included in our review have lagged behind the nation as a whole, delays in making settlements have been a nationwide problem. At September 30, 1970, there were 6,820 hospitals for which first-year final settlements were required and 7,049 hospitals for which second-year settlements were required, including those no longer participating in the program. SSA statistics showed that at that date about 79 percent of the hospitals had made final settlements for their first reporting periods and that about 55 percent had made final settlements for their second reporting periods. There were also significant delays in making final settlements with about 5,000 ECFs for which settlements were required.

CHAPTER 2

DELAYS IN SETTLEMENTS WITH HOSPITALS ATTRIBUTED TO SSA'S ADMINISTRATION OF PROGRAM

Intermediaries, their audit subcontractors, and hospitals advised us that delays in the various steps of the settlement process had been caused, in part, by difficulties arising from SSA's administration of the Medicare program. The problem areas which were cited most frequently involved (1) the untimeliness and unreliability of certain SSA-generated financial and statistical data which were intended to be used in the preparation and audit of cost reports and (2) the combination method of apportioning hospital costs between Medicare and non-Medicare patients, as provided in SSA's reimbursement principles, which the intermediaries considered questionable because its use resulted in Medicare payments that included certain private room costs, which were not covered under the program, and certain delivery room costs, which were not applicable to Medicare patients.

DIFFICULTIES WITH SSA-GENERATED FINANCIAL AND STATISTICAL DATA

Under SSA's contracts with its intermediaries, SSA assumed the responsibility for (1) maintaining a master record of eligibility and claims history of Medicare beneficiaries and (2) furnishing pertinent information to intermediaries and hospitals. SSA also agreed to furnish intermediaries with information related to accepted or rejected claims.

As a by-product of its central data processing functions, SSA developed for use by intermediaries and hospitals a Monthly Provider Statistical and Reimbursement Report (reimbursement report) which represented an accumulation of certain statistical and financial data developed from hospital bills processed by SSA. The reimbursement reports which were to be furnished to hospitals by the intermediaries were to include, for all Medicare patients who had been treated in each hospital, such information as admission and discharge statistics, hospital charges for covered

services furnished, deductible and coinsurance amounts, and interim payments made by the intermediary.

Among the purposes of the reimbursement reports were (1) assisting hospitals in preparing cost reports and (2) guiding intermediaries in making audits and final settlements. According to SSA, timely and reliable reimbursement reports would facilitate the settlement process, particularly by providing hospitals and intermediaries with information on hospital charges and patient-days for Medicare patients which could be used by them to check the accuracy of similar data developed by the hospitals. The Medicare charge and patient-day data are used by hospitals in apportioning allowable costs between Medicare and non-Medicare patients and therefore represent key information in the preparation and audit of cost reports.

SSA's problems in producing accurate and timely reimbursement reports were cited by hospitals and their accountants as causes for delays in the preparation of cost reports and by intermediaries and their audit subcontractors as causes for delays in making audits and final settlements. As a result, at least seven of the 13 intermediaries included in our review found it necessary to accumulate similar statistical data to make settlements with hospitals.

In April 1970 officials at one intermediary that serviced about 320 hospitals during the first reporting period and about 350 hospitals during the second and third reporting periods advised us that, because the SSA reimbursement reports were not useful, they had not opened the boxes containing the reports furnished by SSA. Officials at another intermediary that serviced about 230 hospitals during the first three reporting periods advised us that the SSA reimbursement reports were inaccurate and unreliable and that, although they had retained the most recent reports, they had not used them.

Problems in developing timely and reliable reimbursement reports

During the 3-year period ended March 1970, SSA made several changes to the content and format of its reimbursement reports to make them more useful in the settlement

process. The most important revision, made in March 1969, involved the development of a supplemental, detailed printout of bills to support the summary data shown on the report. SSA anticipated that this detailed printout would facilitate the hospitals' and intermediaries' task of reconciling Medicare charges as reported by the hospitals and by SSA. In March 1970, however, SSA officials advised us that the following problems with the reimbursement reports continued to exist.

--SSA had a backlog of about 117,000 adjustment actions to correct claims data previously included in the reports.

--SSA had not completed a project to establish controls which would ensure resubmission of bills returned to the intermediary for correction. Without such controls SSA had no assurance that the amounts shown on the reimbursement reports included all bills submitted by a hospital for a given accounting period.

--Although SSA issued corrective instructions to intermediaries and hospitals in March 1969, some bills submitted at the end of the hospitals' accounting periods included charges for two cost-reporting periods. The charges shown on these bills, commonly referred to as straddle bills, had to be prorated by SSA between the two cost-reporting periods.

In commenting on these problems, HEW pointed out to us in a letter dated September 28, 1970 (see app. I), that much of the difficulty was attributable to delays by the hospitals and intermediaries in processing bills. HEW stated that a period of about 60 days elapsed from the date that patients were discharged from the hospitals until the date that SSA received the bills. We agree that delays in receiving hospital bills have contributed to SSA's problems in developing timely and reliable reimbursement reports. We noted, however, that, even after the bills were received, it took SSA--on the average--about 30 days to process them.

Intermediaries develop their own reimbursement reports

Although in August 1967 SSA advised its intermediaries not to establish and maintain records that would duplicate the SSA reimbursement reports, at least seven of the 13 intermediaries included in our review had accumulated data similar to that contained in the SSA reimbursement reports to facilitate the settlement process. Intermediary personnel informed us that their decisions to do this had been based on the assumption that they could produce more timely information similar to that included in the SSA reimbursement reports.

For example, at March 31, 1970, one intermediary which serviced 22 hospitals had made final settlements with all the hospitals for the first, second, and third reporting periods. This intermediary had assisted the hospitals in preparing cost reports by furnishing certain statistical and reimbursement information developed from its own records after it had compared its records with the SSA reimbursement reports and had found material differences.

For 20 hospitals we compared data shown on the SSA reimbursement reports which were dated 75 days after the close of the hospitals' first reporting periods with similar information maintained by the intermediary and noted that the number of inpatient-days for Medicare patients and the amounts of interim payments apparently had been understated by as much as 10 percent on the SSA reimbursement reports. In later SSA reimbursement reports dated about 5 months after the end of the hospitals' reporting periods, however, the amounts of these differences were significantly reduced.

Because the statistical and payment data applicable to a specific hospital's reporting period have been continually updated and corrected by SSA, it appears that reimbursement reports can be used by SSA for such purposes as developing program statistics and making comparisons between hospitals; however, the reports have not proved to be an effective and useful tool for hospitals and intermediaries in the settlement process because of the problems in producing reliable data on a timely basis.

ELIMINATION OF QUESTIONABLE METHOD OF APPORTIONING HOSPITAL COSTS WOULD REDUCE MEDICARE PAYMENTS BY MORE THAN $100 MILLION ANNUALLY

A significant reason for delays in final settlements given by certain intermediaries involved the use of the combination method of apportioning allowable costs between Medicare and non-Medicare patients because under this method private room costs, which were not covered under the Medicare program, and delivery room costs, which were not applicable to Medicare beneficiaries, were included in the amount of costs apportioned to Medicare patients. We believe that elimination of the use of the combination method would reduce Medicare payments to hospitals by between $100 million and $200 million annually.

Because reimbursement instructions were lacking in the initial stages of the program, SSA in September 1967 advised its intermediaries that:

> "Where the intermediary exercises judgment and applies generally accepted accounting principles in areas where there is an absence of detailed implementing instructions or interpretations of the Principles, its decision will be acceptable and will be supported by the Social Security Administration."

Some intermediaries were reluctant to follow this advice. Three intermediaries, in particular, advised us in 1968 that they were not making final settlements or were making conditional final settlements pending an official clarification by SSA regarding their questions concerning the higher payments to hospitals that resulted from the use of the combination method of apportioning allowable costs. One intermediary, which serviced about 160 hospitals during the first three reporting periods, did not make any final settlements until March 1970.

Authorized methods of apportioning allowable costs

The reimbursement principles initially authorized several methods for use by hospitals in apportioning allowable costs between Medicare patients and other patients. The three principal methods were designated as the departmental method, the combination method with cost finding, and the combination method with estimated percentages. These apportionment methods were developed to provide means for compliance with the statutory requirement that the costs of services provided to Medicare patients not be borne by non-Medicare patients and that the costs of services provided to non-Medicare patients not be borne by the Medicare program.

Departmental method

Under the departmental method the charges to Medicare patients for services provided in each revenue-producing department or activity are established as a percentage of total charges to all patients receiving the services of each department. The percentage for each revenue-producing department then is applied to the costs of that department to determine the costs of services rendered to Medicare patients.

Under this method the hospital is required to allocate allowable costs--referred to as cost finding--to routine services (such as room, board, and nursing services) and to each of the various ancillary departments (such as X-ray, operating room, and pharmacy). We believe that the departmental method is the most precise of the three apportionment methods.

Combination method with cost finding

The amount of allowable costs apportioned under the combination method with cost finding is computed in two steps. First, the costs for routine services are divided by total inpatient-days for all inpatients to arrive at an average per diem rate per inpatient. This rate is multiplied by the total number of inpatient-days for Medicare inpatients to determine the amount to be reimbursed for the costs of routine services.

The second step involves establishing a percentage relationship between total inpatient charges and total Medicare inpatient charges for all ancillary services. The Medicare reimbursement for ancillary services then is determined by applying this composite percentage to the total costs of ancillary or special services. (See table on p. 22.)

Combination method with estimated percentages

The amount of allowable costs apportioned to Medicare patients under this method is computed in generally the same manner as that of the combination method with cost finding, except that the allocation of costs between total ancillary services and routine services is based on percentages obtained from the intermediary (for example, 40 percent of the costs is estimated to be applicable to ancillary services and 60 percent is estimated to be applicable to routine services). In our opinion, this is the least precise of the three apportionment methods.

For reporting periods ended during calendar years 1966 and 1967, the use of this method was optional on the part of a hospital. For reporting periods ended during calendar year 1968, this method could be used when the intermediary determined that a hospital could not apply the cost-finding procedures. For reporting periods ended after December 31, 1968, this method was no longer authorized.

Intermediary questions regarding combination method

Some intermediaries questioned the use of the combination method because under this method the amount of Medicare reimbursements was generally higher than the amount under the departmental method for two reasons that were considered by the intermediaries to be inconsistent with the Medicare law. First, certain hospitals with a preponderance of private rooms received increased Medicare reimbursements under the combination method because the average cost per day for routine services apportioned to the Medicare program included the higher costs of private rooms. The costs of private accommodations were not covered under the Medicare program unless such accommodations were determined to be medically necessary.

Second, under the combination method the inclusion of delivery room costs in total ancillary costs also resulted in higher reimbursements to hospital because (1) such services were not furnished to Medicare patients and (2) the ratio of costs to charges for delivery rooms, which generally are operated at a loss, was usually substantially different from the ratios of costs to charges for other ancillary service departments, which generally are operated at a profit. This variance in ratios had the effect of distorting the composite ratio used in the combination method. The effect of using the combination method to apportion ancillary costs, compared with the more precise departmental method, is illustrated in a hypothetical case shown in the following table.

Ancillary service department	Charges to all patients	Charges to Medicare patients	Percent of Medicare charges to total charges	Total allowable costs	Allowable costs apportioned to Medicare program (col. 3X4)	
					Combination method	Departmental method
	(1)	(2)	(3)	(4)	(5)	(6)
Operating room	$100,000	$ 25,000	25	$ 80,000	$ -	$ 20,000
Delivery room	35,000	-	-	70,000	-	-
X-ray	100,000	35,000	35	60,000	-	21,000
Laboratories	200,000	70,000	35	120,000	-	42,000
Medical supplies sold	100,000	30,000	30	80,000	-	24,000
Drugs sold	150,000	60,000	40	100,000	-	40,000
Total	$685,000	$220,000	32	$510,000	$163,200	$147,000

We noted that, as early as January 1967, one intermediary included in our review, which serviced about 160 hospitals, had contacted BCA regarding the propriety of using the combination method for computing costs apportioned to Medicare. In later correspondence with BCA, the intermediary included an example which showed that a hospital, by using the combination method rather than the departmental method, would receive additional reimbursements of about $528,000 annually.

The intermediary concluded that:

> "Because there is an apparent loophole in the Medicare method of reimbursement, this matter is being called to your attention for whatever action you might wish to take."

In March 1968 another intermediary included in our review, which serviced 23 hospitals, requested a decision from BCA regarding the inclusion of such non-Medicare-related costs as delivery rooms. The BCA reply dated March 27, 1968, included the following comments.

> "*** I recommend that you proceed to finalize not only your 1966 cost reports but also your 1967 cost reports without exclusion of these costs. As a general operating principle, we should not deduct cost from a provider's cost report which the existing rules and regulations allow. As the Medicare Program is refined and changes are introduced, they will be made on a prospective basis so that the providers and Intermediaries will be able to institute the changes on an equitable basis and with the minimum of friction."

Comments of HEW General Counsel and HEW Audit Agency on use of combination method

In November 1967 the HEW Assistant General Counsel for Health Insurance issued a memorandum to an SSA official concerning the intermediaries' questions relating to the inclusion of private room costs and delivery room costs in the Medicare reimbursement formula. This memorandum

referred to Medicare reimbursement regulation which stated that:

> "(b) *** The reasonable cost of private room accommodations is covered in full only where their use is medically indicated, ordinarily only when a patient's condition requires him to be isolated. Where private accommodations are furnished for a patient's comfort, the amount payable under this Subpart A may not exceed the reasonable cost of accommodations containing from two to four beds. ***"

Although the regulation recognized that a difference existed in the costs of different types of accommodations, the regulation did not provide specific guidelines on how this difference was to be determined and shown in the cost report.

The Assistant General Counsel's memorandum stated that delivery room costs should be excluded in determining costs apportioned to Medicare. The memorandum provided, in part, that:

> "We believe that the inclusion of delivery room costs in the reimbursement formula is clearly in error for the reason that such costs are in no way related to the cost of services furnished to beneficiaries, and hence cannot, under the provider cost reimbursement regulations be charged or apportioned to the Title XVIII program.
>
> "*** In the context of a program limited to beneficiaries who are over age 65, the costs of delivery room services are not allowable costs and hence may not be charged to the program regardless of which method of apportionment is chosen by the provider.
>
> "Under the departmental method of apportionment, the cost of delivery rooms may not be charged against the program because medicare beneficiaries do not use the facilities in question.

The same is true with respect to the combination method of apportionment."

In a February 1970 report to the Commissioner of Social Security, the HEW Audit Agency recommended that the combination method of apportioning costs to the Medicare program be eliminated or modified because it resulted in a hospital's being reimbursed for costs applicable to private room accommodations and to delivery rooms, which appeared to be specifically excluded from reasonable costs as defined in the Medicare law.

Differences among methods of apportionment

As mentioned previously, delays in making final settlements were attributed by certain intermediaries to questions involving the different apportionment methods authorized by SSA. To determine the significance of these questions, we examined 139 first-year and 100 second-year hospital cost reports for hospitals in 32 states and Puerto Rico for which final settlement had been made by various intermediaries. A summary of Medicare inpatient costs allowed under each reimbursement method for the audited cost reports included in our sample follows.

Apportionment method used	Hospital cost reports		Medicare inpatient costs allowed	
	Number	Percent (note a)	Amount (000 omitted)	Percent (note b)
Departmental	29	12	$ 5,631	8
Combination with cost finding	103	43	42,003	56
Combination with estimated percentages	107	45	26,818	36
Total	239	100	$74,452	100

[a]SSA made a comparable analysis of about 1,000 first-year hospital cost reports. SSA's analysis showed that about 9 percent of the hospitals had used the departmental apportionment method, that about 46 percent had used the combination method with cost finding, and that about 45 percent had used the combination method with estimated percentages.

[b]The 1,000 first-year cost reports analyzed by SSA involved Medicare inpatient costs of about $215 million. This analysis showed that about 7 percent of the costs had been apportioned to Medicare on the basis of the departmental method, that about 61 percent of the costs had been apportioned on the basis of the combination method with cost finding, and that about 32 percent had been apportioned on the basis of the combination method with estimated percentages.

For 100 of the 103 hospitals in our sample that used the combination method with cost finding, we were able to compare the amounts of Medicare costs allowed with the amounts of Medicare costs that would have been allowed if the departmental method had been used.

Our comparison showed that the Medicare program costs allowed under the combination method had been $40,810,000 and that the program costs under the departmental method would have been $39,117,000--a difference of $1,693,000, or about 4 percent of the costs allowed. Further, our analysis of this 4-percent difference by size of hospital--a comparison of the costs for hospitals with less than 100 beds with the costs for hospitals with 100 or more beds--showed that, for hospitals in both groups, the differences in the amounts of Medicare costs allowed had averaged about 4 percent.

Of the total difference of $1,693,000, about $320,000, or 20 percent, was attributable to routine service costs, including the private room differential, and about $1,373,000, or 80 percent, was attributable to ancillary costs. About $627,000, or 46 percent of the $1,373,000, was due to the inclusion of delivery room costs in the combination method.

Because of the lack of final settlements, a random sample of audited cost reports for all hospitals for the first two reporting periods could not be developed. We believe, however, that, programwide, the differences between the costs apportioned to the Medicare program under the departmental and combination methods of apportionment are significant.

Both our analysis of 239 first-year and second-year hospital cost reports and SSA's analysis of about 1,000 first-year hospital cost reports showed that only about 10 percent of the hospitals had elected to use the more accurate departmental method. We believe that it is reasonable to assume that those hospitals that used the combination method with cost finding elected to do so because its use resulted in higher Medicare reimbursements.

Benefit payments for inpatient hospital care totaled about $4.4 billion in fiscal year 1970, and SSA estimated that these payments would total about $5.8 billion in fiscal year 1971. Therefore, if the results of our sample of audited cost reports are representative for those hospitals that used the combination method with cost finding for the first two reporting periods, the elimination of that method of apportioning costs would result in a reduction of Medicare payments to hospitals by over $100 million annually.

Further, we are aware of some instances during the early years of the program in which hospitals elected to use the combination method with estimated percentages because its use resulted in higher Medicare reimbursements than either of the apportionment methods which required cost finding. Therefore, if the 4-percent difference between the amounts apportioned to Medicare under the combination method and the departmental method also applied to those hospitals that used the combination method with estimated percentages for the first two reporting periods but that were required to use cost-finding procedures for subsequent periods, the elimination of the combination method could reduce annual Medicare payments to hospitals by as much as $200 million annually.

Delays by SSA in resolving questions regarding methods of apportionment

In May 1968 SSA furnished BCA and other intermediaries with a tentative and preliminary draft of certain instructions dealing with the use of the combination method of apportionment. These instructions were to be applied for reporting periods ended after June 30, 1968.

Regarding the apportionment of the costs of routine services for hospitals that had several types of accommodations (private rooms, semiprivate rooms, and wards), the draft instructions provided that, in preparing cost reports, the hospitals give recognition to cost differences which could be attributable to the space utilized (such as depreciation, maintenance, and housekeeping expenses). Other costs not related to space were to be apportioned in the normal method on the basis of inpatient-days. Regarding delivery room costs, the May 1968 draft stated, in part, that:

> "Total allowable costs of a provider shall be apportioned between program beneficiaries and other patients so that the share borne by the program is based upon actual services received by program beneficiaries.
>
> "Thus, the regulations require that provider costs be apportioned so that the program pays only for services that are actually rendered to beneficiaries. Where services such as delivery room are not used by program beneficiaries, the costs of such services may not be included in allowable costs. Moreover, the charges applicable to the cost of such excluded services should be excluded from total patient charges for ancillary services in developing the ratio to determine the program's share of ancillary costs."
> (Underscoring supplied)

The draft instructions were not finalized by SSA. In response to an inquiry from a congressional subcommittee, SSA stated in August 1969 that its intermediaries had advised SSA that the proposed instructions would not be fair

to the hospitals because, in apportioning costs to Medicare, they did not consider all elements of cost, such as nursing costs which were incurred to a greater degree by Medicare patients than by non-Medicare patients.

SSA stated also that, because it had not satisfied the concern of hospitals about the Medicare program's paying its full share of nursing costs and in the light of the action taken by HEW in June 1969 to eliminate from the reasonable-cost formula the 2-percent allowance in lieu of specific recognition of other costs,[1] SSA believed that it was inappropriate to impose a policy which would result in further reducing the program's share of hospital costs.

In November 1969 SSA advised the American Hospital Association that it was prepared to modify the Medicare reimbursement formula to recognize a nursing-cost differential of up to 8-1/2 percent of nurses' salaries. SSA estimated that this modification would result in an increase of Medicare reimbursements to providers of about 1.2 percent. For fiscal years 1970 and 1971, SSA estimated that these increased costs would be $60 million and $75 million, respectively.

In April 1970, in responding to the February 1970 HEW Audit Agency recommendations (see p. 25) to eliminate or modify the combination method of apportionment, SSA stated that the whole question of the combination method would be evaluated but that it would be a mistake to move too quickly to eliminate the combination method for apportioning hospital costs because of the impreciseness of any apportionment method.

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[1]Under the original (November 1966) "Principles of Reimbursement for Provider Costs", an allowance for costs not specifically recognized was included as an element of allowable costs. For all providers except proprietary institutions, this allowance was 2 percent of the total other allowable costs, after excluding interest expense. For proprietary institutions, the allowance was 1-1/2 percent of other allowable costs, after excluding interest expense and the return allowed to such institutions on their equity capital.

GAO observations concerning
use of combination method

We recognize that any method of apportioning allowable costs between Medicare and non-Medicare patients which is to be applicable to about 7,000 hospitals will result in approximations which will be subject to continuing modifications and adjustments if some definite and uniform reimbursement formula is not established. We recognize also that, as long as the combination method with estimated percentages (which did not require the use of cost-finding procedures) was authorized to be used to allocate costs between routine services and total ancillary services, a determination of the direct and indirect costs of any particular ancillary department or service, such as delivery rooms, might not have been possible for all hospitals.

As noted on page 21, however, effective with reporting periods ended after December 31, 1968, the combination method with estimated percentages was no longer authorized, and all hospitals were required to use cost-finding procedures. Therefore the only essential difference between the departmental method and the combination method insofar as hospital recordkeeping is concerned is that under the departmental method the Medicare and non-Medicare charge data must be maintained for each ancillary department whereas under the combination method the Medicare and non-Medicare charge data must be maintained only for total ancillary charges.

Under these circumstances it appears that most hospitals participating in the Medicare program should have the capability to use the more precise departmental method for apportioning the costs of ancillary services.

CONCLUSIONS

The settlement process was delayed by SSA's problems in producing timely and accurate provider reimbursement reports which could be used by hospitals in preparing their cost reports and by the intermediaries in the audit of the cost reports. We believe that SSA should establish a definite timetable for developing timely and reliable reimbursement reports that can be useful to hospitals and intermediaries in the settlement process or should consider other alternatives, such as authorizing intermediaries to prepare reimbursement reports.

The use of the combination method of apportioning hospital costs between Medicare and non-Medicare patients resulted in increased costs to the program through inclusion of costs which either were not covered under the program or were not applicable to Medicare beneficiaries. In addition, the option to use this method resulted in delays in making final settlements by some intermediaries because they considered its use inconsistent with the Medicare law. We therefore believe that the option of hospitals to use the combination method should be discontinued, at least as a basis for apportioning the costs of ancillary services.

RECOMMENDATIONS TO THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE

We recommend that HEW (1) provide for SSA to establish a definite timetable for the development of effective, useful, and timely provider reimbursement reports for use by hospitals and intermediaries in the settlement process or consider other alternatives, such as authorizing intermediaries to prepare the reports and (2) discontinue or modify the use of the combination method of apportioning hospital costs between Medicare and non-Medicare patients.

AGENCY COMMENTS AND ACTIONS AND GAO EVALUATION

In a letter dated September 28, 1970, HEW furnished us with its comments on our findings and recommendations. (See app. I.)

Provider reimbursement reports

Regarding SSA's problems in producing timely and reliable provider reimbursement reports for use in the settlement process, HEW advised us that SSA had decided to concentrate on actions to overcome the problems encountered, rather than to consider alternatives, such as authorizing intermediaries to prepare reimbursement reports, and that, accordingly, SSA did not intend to discontinue preparing the reimbursement reports. According to SSA, most of its problems were associated with processing the bills rather than with its inability to produce the necessary data. SSA pointed out that it was experiencing 60-day delays in receiving the bills from the hospitals and intermediaries.

HEW expressed the belief that the potential of the reports as a tool for internal administration and appraisal warranted continuing their preparation. HEW also stated that there were economies to be obtained by SSA's producing the reports as a by-product of its central data processing operations rather than having each intermediary produce the reports. HEW listed seven steps that SSA proposed to take to find solutions to the problems that had hindered it in producing effective, useful, and timely reports.

Regarding HEW's comments concerning the delays in processing bills by hospitals and intermediaries, our review of SSA statistics indicated that, during calendar years 1969 and 1970, the average total times for processing an inpatient hospital bill[1] were about 90 days and 100 days, respectively. About 60 days elapsed after the intermediary had approved the bills. In other words, there was a period of about 30 days between the time that the intermediary approved the bills and SSA received them, and another 30 days elapsed before SSA processed the bills. On the basis of these statistics, it appears to us that the intermediaries are in a position to develop hospital reimbursement and charge data on a more timely basis than SSA.

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[1]The total processing time is calculated from the date of the patient's discharge or the date of the hospital's interim bill to the date that the bill is processed to tape in SSA.

Regarding the steps that SSA proposed to take to find solutions to the problems that had hindered it in producing effective, useful and timely reimbursement reports, we noted that actions similar to three of the seven steps cited by HEW had been attempted by SSA at various times after the origination of the reimbursement reports in January 1967 without solving the problems.

Combination method

In commenting on our recommendation to discontinue or modify the use of the combination method of apportioning hospital costs, HEW stated that reducing or minimizing Medicare payments to hospitals was not a legitimate objective in itself in view of the congressional mandate that hospitals be reimbursed for the reasonable costs of providing services to Medicare patients.

HEW advised us that SSA had been giving intense study to the combination method as part of its complete reexamination of Medicare cost reimbursement. HEW advised us also that these studies had shown that it might achieve its objective of determining full reasonable costs of services provided to Medicare beneficiaries by restricting the use of the combination method to certain types or sizes of facilities. We were further advised that HEW was in the process of reaching a decision on this matter and would advise us when the final decision was made.

In January 1971 HEW informed us that, in accordance with an agreement with the Senate Committee on Finance, a decision had been made to require larger providers (e.g., those having 100 or more beds) to use the more accurate departmental method to apportion costs to the Medicare program. The smaller providers (e.g., those having less than 100 beds) will be required to use a more simplified method of apportionment. HEW expected these new requirements to apply to reporting periods beginning on or after July 1, 1971.

Although over half of the number of hospitals participating in the Medicare program have less than 100 beds, during fiscal year 1970 about 20 percent of the Medicare payments to hospitals for inpatient services were made to

hospitals having less than 100 beds and 80 percent of the payments were made to hospitals having 100 or more beds. Therefore we estimate that HEW's decision to discontinue the use of the combination method of apportioning costs by the larger hospitals could result in a reduction of Medicare payments to hospitals of from $80 million to $160 million annually.[1]

The foregoing changes in reimbursement methods will require changes in the Code of Federal Regulations pertaining to Medicare. In accordance with the Administrative Procedure Act (5 U.S.C. 552 et seq.), HEW has followed the practice of initially publishing such regulation changes in the Federal Register in the form of a proposal, which thereby affords interested parties the opportunity to furnish their views or arguments for consideration by HEW before the changes are adopted finally.

As of April 30, 1971, the changes relating to (1) the use of the departmental method to apportion Medicare costs for larger providers and (2) the use of simplified methods of apportionment for smaller providers had not been published by HEW in their proposed form although HEW had initiated informal consultations with affected parties.

We believe that, before the changes in regulations are finalized, HEW should consider the following matters with regard to reimbursements to hospitals.

1. As pointed out in HEW comments, the reduction of Medicare payments to hospitals is not a legitimate objective in itself. In line with this reasoning, we believe that the departmental method of apportioning the costs of routine services (ratio of Medicare charges to total charges) may be inequitable to some hospitals because the differences between hospital charges for private and semiprivate accommodations may not be representative of the differences in

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[1] In February 1971 testimony before a subcommittee of the House Committee on Appropriations, HEW estimated that the change would save $100 million in Medicare costs for fiscal year 1972.

costs between such accommodations. Therefore we believe that some alternative method of recognizing cost differences between various types of accommodations should be developed by SSA.

2. In our opinion, the number of beds in a hospital should not be the sole criterion for determining whether the departmental apportionment method or a more simplified method should be used for Medicare reimbursement purposes. For example, there is not necessarily a relationship between the number of beds in a hospital and the level of hospital expenses because of such factors as the type of hospital (long-term or short-term) and the variances in the types of services furnished.

From data obtained from material published by the American Hospital Association, we identified about 250 hospitals in the United States which had between 90 and 100 beds. The annual level of expenses reported by these hospitals ranged from about $400,000 to over $3 million. Overall, about 44 percent of the 250 hospitals had reported annual expenses of less than $1 million, about 47 percent had reported annual expenses of between $1 million and $2 million, and about 9 percent had reported annual expenses of over $2 million.

Also a hospital's bed capacity would not necessarily be indicative of the amount of Medicare reimbursement because of the variances in the level of expenses as well as variances in the extent that Medicare patients used hospital facilities.

For example, in our sample of 100 second-year cost reports (see p. 26), we noted that the annual Medicare reimbursable costs for hospitals having 50 to 99 beds had ranged from about $80,000 to about $500,000 whereas the annual Medicare reimbursable costs for hospitals having 100 to 150 beds had ranged from about $20,000 to about $675,000. Although there was an overall tendency for the hospitals having the higher number of beds to receive the higher Medicare reimbursement, we noted that about 30 percent of the hospitals having 50 to 99 beds had Medicare costs of over $300,000 a year whereas about 17 percent of the hospitals having 100 to 150 beds had Medicare costs of less than $300,000.

We believe that the total hospital expenses and the previous Medicare reimbursements should be included among the factors to be considered in determining whether the departmental or a simplified apportionment method should be authorized for hospitals.

CHAPTER 3

DELAYS BY HOSPITALS IN SUBMITTING COST REPORTS

SSA instructions require that, within 90 days after the end of a provider's accounting period, a cost report be filed with the intermediary.[1] For the first reporting period, only about 150 hospitals, or less than 7 percent, of the 2,245 hospitals serviced by the 13 Blue Cross Plans submitted first-year cost reports within the prescribed 90-day period.

The graph on page 40 shows the rate of submission of cost reports to the 13 intermediaries during the 2-1/2-year period from March 31, 1968, through September 30, 1970, for accounting periods ended on or before June 30, 1967 (first-year reports), June 30, 1968 (second-year reports), and June 30, 1969 (third-year reports).

At March 31, 1968, about 1,610 hospitals, or about 72 percent, had submitted first-year cost reports. Excluding the 150 hospitals that had filed on time, the remaining 1,460 hospitals were, on the average, about 4 months late. The 635 hospitals that had not filed first-year cost reports at March 31, 1968, were, on the average, about 9 months late at that time. At September 30, 1970, or 3 years after the first-year cost reports were due, about 1 percent of the hospitals still had not filed first-year cost reports.

We did not note any improvement in the submission of second-year cost reports. For example, as indicated by the graph, at March 31, 1968, and September 30, 1968, respectively, 72 percent and 87 percent of the first-year cost reports had been submitted to the intermediaries. At comparable times applicable to the second-year cost reports (March 31, 1969 and September 30, 1969), about 62 percent and 83 percent, respectively, of the 2325 second-year cost reports had been filed.

Furthermore, although all 2325 third-year cost reports were due by September 30, 1969, only about 40 percent of

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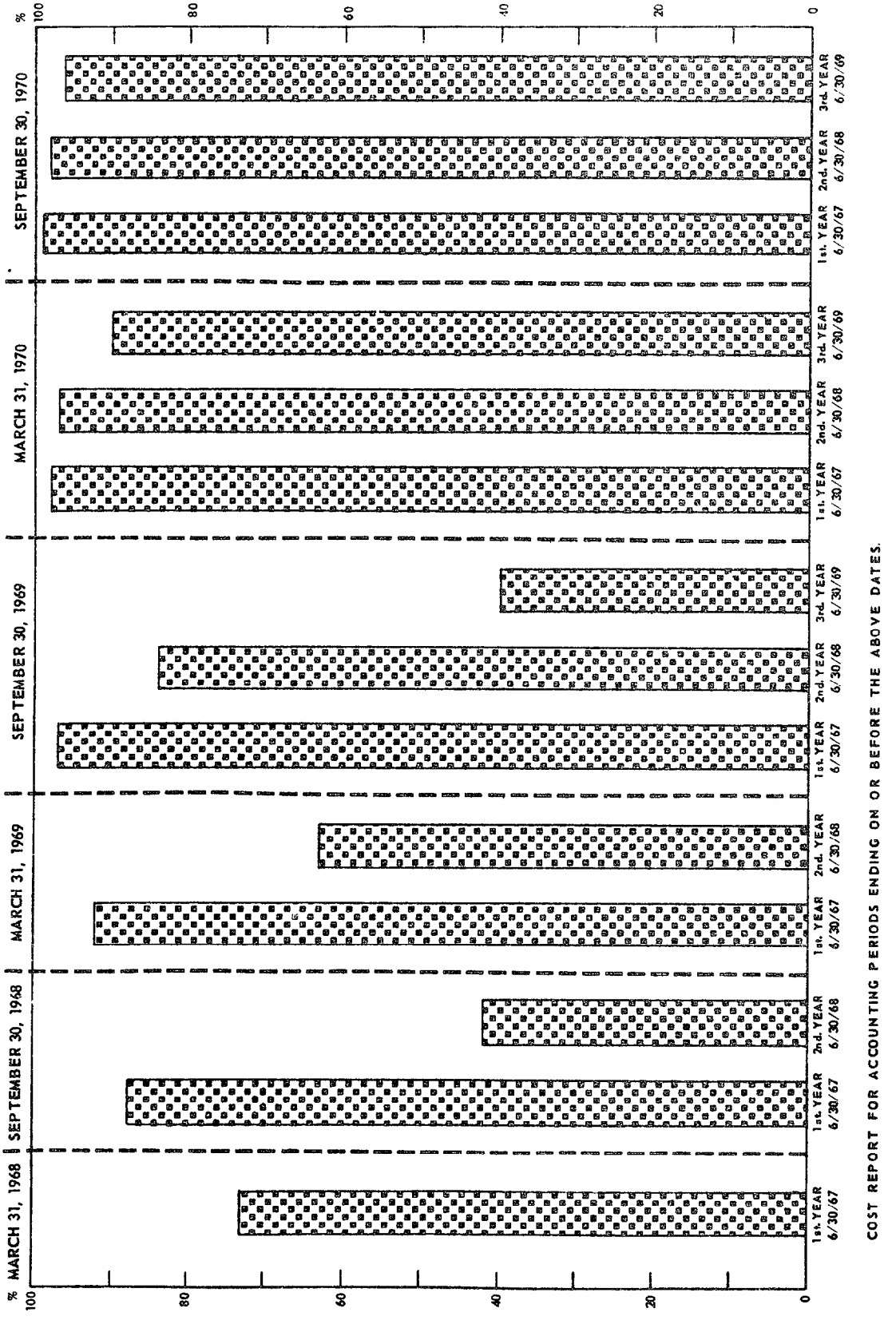
[1] See footnote on p. 13.

these reports had been submitted by that time. There was some later improvement, however, in the submission of third-year cost reports. For example, at March 31, 1970, about 90 percent of the third-year cost reports had been filed; whereas, at comparable times applicable to the first and second reporting periods (March 31, 1968 and 1969), 72 percent and 62 percent, respectively, of the cost reports had been filed.



COST REPORT FOR ACCOUNTING PERIODS ENDING ON OR BEFORE THE ABOVE DATES.

CAUSES OF DELAYS IN SUBMISSION OF COST REPORTS

Some of the causes of delays in the submission of cost reports by hospitals were unique to the first or second reporting periods and would not necessarily represent problem areas for future reporting periods. Other causes seemed to represent continuing problems in administration of the program.

The most common causes of delays which could be attributed to the newness of the program were as follows:

1. Decisions by hospitals and intermediaries in certain geographical areas to devise special cost report forms which generally were not made available for use until several months after the end of the first-year reporting periods.

2. Lack of appraisals of property on which claims for depreciation expense were to be based.

3. Lack of SSA instructions regarding methods of apportioning costs between Medicare and non-Medicare patients for certain hospitals which (a) charged all patients a single all-inclusive daily rate, regardless of the services received, or (b) made no charges at all.

4. Difficulties encountered by hospitals in obtaining agreements with hospital-based physicians to determine amounts to be claimed for reimbursement as a hospital cost under part A of the Medicare program and amounts to be claimed as physicians' services to individual patients under part B of the program.

We believe that many steps have been taken by SSA, the intermediaries, and the hospitals to alleviate these causes of delays.

Continuing causes of delays

Other causes of delays in the submission of cost reports by hospitals were (1) inadequacies in hospital

accounting systems and insufficient numbers of hospital personnel capable of preparing Medicare cost reports and (2) delays by accounting firms employed by hospitals in completing financial audits before submission of cost reports.

Our observations relating to these problem areas are set forth below.

Inadequacies in hospital accounting systems and insufficient numbers of hospital personnel qualified to prepare reports

Representatives of hospitals, intermediaries, and accounting firms responsible for auditing hospitals' Medicare cost reports most frequently cited the following causes for delays in submitting cost reports.

1. Problems associated with adapting rather unsophisticated hospital accounting systems to the Medicare cost-reimbursement principles and related reporting requirements.

2. Insufficient numbers of hospital personnel capable of preparing cost reports.

These problems were particularly troublesome to smaller hospitals.[1]

With the exception of certain governmental institutions that used the cash basis of accounting, SSA principles of reimbursement required that cost reports be prepared on the accrual basis of accounting. Under the accrual basis, revenues were to be recognized in the period earned, regardless of when billed or collected, and costs were to be recognized in the period incurred, regardless of when paid. The use of the accrual basis of accounting required modifications to

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[1] About 55 percent of the hospitals included in our review and about 50 percent of all hospitals participating in the Medicare program are facilities with less than 100 beds.

hospital accounting practices, such as (1) developing inventory systems to account for supplies when used rather than when purchased and (2) recording revenues during the period services were furnished rather than at the time the patient was discharged.

The SSA principles of reimbursement also required that charges for services rendered to Medicare patients be separated from charges for services rendered to non-Medicare patients. This separation is necessary for developing a ratio of charges to Medicare patients to total patient charges, which is the basis for apportioning costs between Medicare and non-Medicare patients.

As discussed in chapter 2, when the SSA reimbursement report proved unreliable for providing these data and when a hospital's accounting system failed to provide a systematic segregation of charges between Medicare and non-Medicare patients, this information had to be compiled retroactively by the relatively few hospital personnel qualified to perform this task.

Because data needed to properly allocate hospital overhead costs to revenue-producing departments had not been systematically accumulated by many hospitals, it was necessary to compile such data through examination of various source documents. This was a time-consuming task which relatively few hospital employees were available to perform.

To deal with the anticipated problem of inadequacies in hospital accounting systems, the SSA contracts with the intermediaries provided that one of the intermediaries' functions was to assist hospitals in establishing and maintaining fiscal records to meet the purposes of the Medicare act.

In fulfilling this contractual provision, BCA and its subcontractors conducted or participated in numerous seminars and other educational activities to familiarize hospital personnel with SSA's principles of reimbursement and related requirements concerning the preparation of Medicare cost reports. As indicated by the results of our review, the success of these educational activities varied.

Differences in intermediary workloads and in the nature and size of hospitals serviced made it difficult to make comparative evaluations of intermediary performance. We noted, however, that four of the 13 intermediaries included in our review had achieved comparatively good results in obtaining timely cost reports from hospitals by furnishing hospitals onsite assistance in preparing their first-year Medicare cost reports.

For example, for the first reporting period, one Blue Cross Plan which serviced 22 hospitals followed the practice of granting a hospital one 30-day extension, and, if the report was not received within that time, the Plan's personnel visited the hospital and actively assisted hospital personnel in preparing the cost report. Early in the program, a second Blue Cross Plan which serviced about 105 hospitals established a separate division within its organization to actively assist the hospitals in adapting their accounting system to meet Medicare cost reporting requirements.

At March 31, 1970, the first Plan received and made settlements for all first-, second-, and third-year cost reports. For the first three reporting periods, the second Plan received cost reports from about 74 percent of its hospitals within 3 months after the dates that the reports were due.

Delays by accounting firms in completing regular hospital audits

Another cause of delays in the submission of hospital cost reports frequently cited by intermediary and hospital personnel was the time required by auditing firms employed by the hospitals to complete their audits of the hospitals' financial statements. In such instances, hospitals delayed submitting their Medicare cost reports until the auditing firms had prepared the report or until the hospitals had decided to submit the cost reports based on unaudited financial data. We noted that hospitals in the same geographical area often had reporting periods ending on the same date. Further these reporting periods often ended during the public accounting profession's busy season--thus reducing the probability that the hospitals' statements would receive early attention by the auditing firms.

The following table shows (1) the Medicare reporting periods, as of March 1970, for the 2,325 hospitals included in our review and (2) the accounting periods for Federal tax reporting purposes for about 5,200 community-type hospitals included in an American Hospital Association nationwide survey. About 37 percent of the hospitals in each sample selected periods ending December 31.

Reporting period ending	Percent for hospitals included in GAO review	Percent for hospitals included in American Hospital Association's survey
Sept. 30	13.0	19.4
Dec. 31	37.2	36.5
June 30	31.2	28.5
Subtotal	81.4	84.4
Other dates	18.6	15.6
Total	100.0	100.0

To meet the due date for submission of Medicare cost reports, hospitals having reporting periods ending on December 31 required that audits of their financial statements be made during the tax season, the peak work load period for the public accounting profession. Because the accounting firms customarily charged hospitals--as nonprofit, service-type organizations--institutional rates which were lower than their usual rates, we noted that hospital audits did not receive top priority during the accounting firms' busy season.

We believe that these delays would be alleviated if certain hospitals, particularly those with fiscal years ending December 31, would change their Medicare reporting periods so that the periods would end when outside professional accounting assistance would be more likely to be available.

The above table shows that over 80 percent of the hostals included both in our review and in the American Hospital Association's nationwide survey selected reporting

periods ending on September 30, December 31, or June 30 for Medicare and Federal tax reporting purposes. As discussed in more detail in chapters 4 and 5, the tendency of hospitals in the same geographical area to select the same Medicare reporting periods also contributed to delays in the desk audit and field audit steps of the settlement process because intermediaries' work loads were not distributed evenly throughout the year.

Steps taken by SSA to reduce delays in submission of cost reports

Early in the program hospitals were advised by a number of Blue Cross Plans that Medicare regulations did not provide for a penalty for late submission of cost reports. Because there were no penalties, there was little incentive for hospitals to submit cost reports within the 90-day period specified by the SSA instructions unless they believed that the payments made by the intermediaries on an estimated basis during the year had been too low. Officials of some hospitals acknowledged to us that they were in no hurry to submit cost reports, because the reports would presumably show that interim payments to their hospitals had been too high and it would be necessary to refund the overpayments to the intermediary.

In November 1967 SSA authorized its intermediaries to reduce interim payments for those hospitals that did not file cost reports within a reasonable period after the cost reports were due. In only a relatively few instances did the 13 intermediaries included in our review take this action.

We believe that the intermediaries' reluctance to use this approach for the first reporting periods of the program was attributable to the fact that many intermediaries were not in a position to process cost reports because of insufficient staff or because SSA had not approved subcontracts for the auditing of the cost reports. Further, the cost reports that had been submitted, in many cases, were incomplete or inaccurate and were either returned to the hospitals for correction or were held by intermediaries pending receipt of additional information. We believe that

the imposition of penalties for the initial reporting periods would have done little to expedite the overall process of making final settlements.

In September 1969 SSA instructed intermediaries to reduce or to suspend interim payments to hospitals and other providers that failed to submit completed cost reports on a timely basis. These instructions provided that interim payments be reduced when a cost report was overdue by 1 month and that payments be suspended when a cost report was overdue by 3 months.

As shown by the graph on page 40, there was an improvement in the submission of third-year cost reports after September 30, 1969, which we believe was attributable, in part, to the steps taken by SSA to impose penalties for submitting late reports. Because our review did not include an evaluation of the accuracy of the cost reports submitted by the hospitals, we could not determine whether the more timely submission of the third-year cost reports would result in expediting the overall settlement process.

CONCLUSIONS

As pointed out on page 44, some intermediaries that have provided onsite assistance to hospitals in adapting their accounting systems to meet Medicare cost reporting requirements or have provided hospitals with onsite assistance in preparing their cost reports have achieved relatively good results in obtaining hospitals' cost reports on a timely basis. For fiscal years 1968 and 1969, the Medicare administrative costs of these intermediaries were not out of line in relation to the administrative costs of other intermediaries of comparable size, which suggested to us that such assistance was not unduly expensive. We believe that other intermediaries could achieve similar results by adopting the approach of providing such onsite assistance where it is needed.

Also, as discussed on pages 45 and 46, we believe that greater diversity in cost reporting periods for hospitals would facilitate (1) the hospitals' obtaining timely outside professional assistance in preparing and auditing cost reports and (2) the intermediaries' processing and auditing of cost reports on a more current basis, through more even distribution of work loads over the year.

RECOMMENDATIONS TO THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE

We recommend, therefore, that the Secretary of HEW, through SSA (1) instruct intermediaries to provide increased onsite assistance to those hospitals which may still need help in adapting their accounting systems to meet Medicare cost-reporting requirements and (2) encourage hospitals to adopt different cost-reporting periods to provide more even distribution of intermediaries' work loads and to facilitate the preparation and/or audit of cost reports by the hospitals' accounting firms.

AGENCY COMMENTS AND ACTIONS AND GAO EVALUATION

BCA, in a letter to SSA dated July 14, 1970, commented on our draft report. (See app. II.)

Increased assistance

BCA stated that it supported our recommendation that intermediaries should provide increased onsite assistance to hospitals in meeting Medicare cost-reporting requirements but further stated that SSA had established very restrictive guidelines concerning the allowable time available for this purpose. HEW's September 28, 1970, letter to us commenting on our recommendations pointed out that, although it agreed with us that during the first years of the program inadequate accounting systems had been the cause of delays in the submission of cost reports, the problem had since been minimized. HEW also advised us, however, that it supported our view that intermediaries should provide onsite assistance in those cases in which providers continued to need it.

Adoption of different cost-reporting periods

Concerning our recommendation that SSA encourage hospitals to adopt different cost-reporting periods, HEW stated that, as an alternative to our proposal, SSA was considering changing its instructions to require that Medicare cost reports cover the same reporting periods and have the same due dates as the providers' annual reports to Internal Revenue Service. HEW stated also that, even if conformity with the Internal Revenue Service's reporting period did not change the date that the provider's cost-reporting year ended, it would affect the date that the provider's cost reports were due and therefore would result in a more even distribution of intermediaries' work load, because all cost reports would not be due at the same time. For example, nongovernmental hospitals' annual reports to the Internal Revenue Service are due from 2-1/2 to 4-1/2 months after the hospitals' reporting periods have ended, depending on the type of organization; whereas, under existing SSA instructions, all provider's cost reports are due (1) within 90 days after the end of a provider's reporting period or (2) within 120 days after the end of a providers reporting period if the provider elects to file a certified cost report. (See pp. 10 and 13.)

Although the proposed changes in SSA instructions may facilitate the intermediaries' processing and auditing of cost reports through more even distributions of work loads

over the year, hospitals' reporting periods, in most instances, are the same for both Medicare and Internal Revenue Service reporting purposes--as shown on the table on page 45. Therefore we believe that, although the proposed change may result in a fewer number of hospitals being delinquent in filing cost reports, it will not necessarily reduce the overall length of time taken to make final settlements. For example, the longest period for filing a cost report under the SSA proposal (4-1/2 months) would be applicable to voluntary nonprofit institutions which represent about 55 percent of the hospitals participating in the Medicare program. For these voluntary nonprofit hospitals, the settlement process would begin 4-1/2 months after the end of a hospital's reporting period rather than 3 months after the end of the reporting period as provided for under the existing instructions.

We believe, however, that the SSA proposal has some merit, particularly where it can be adapted to expedite the overall settlement process. According to SSA's August 1970 instructions to its intermediaries, settlements for hospitals' cost reports that have been certified as accurate by the hospitals' independent auditors would normally be made without field audits by the intermediary and would eliminate one step of the settlement process. Therefore we believe that, if the due dates for submitting Medicare cost reports are extended to conform to the Internal Revenue Service reporting dates, the authority to use the extended due dates could be granted by SSA as an incentive to encourage more hospitals to file certified cost reports and would help shorten the overall settlement process. We suggest SSA consider adopting such an approach.

CHAPTER 4

DELAYS BY INTERMEDIARIES IN DESK AUDITS OF HOSPITAL COST REPORTS

After the hospitals' Medicare cost reports are submitted to intermediaries, the second step of the settlement process involves (1) desk audits of the cost reports by the intermediaries to ascertain whether the reports are complete and to detect obvious errors or inconsistencies and (2) tentative settlements, under which excessive interim payments are to be recovered from hospitals or any amounts due hospitals are to be paid as promptly as practicable. The desk audits of cost reports are also the basis for adjusting interim payment rates to hospitals.

Although practices followed by each of the 13 intermediaries in making desk audits and tentative settlements varied, we believe that these intermediaries could be placed into two groups. One group--nine intermediaries, servicing about 1,230 hospitals during the first reporting period--generally made detailed desk audits, returned incomplete or erroneous cost reports to hospitals for correction, and made tentative settlements on the basis of the hospitals' corrected reports. The other group--four intermediaries, servicing about 1,015 hospitals during the first reporting period--generally did not perform all or some of these functions.

The causes and the extent of any delays experienced by these two groups and steps taken by SSA to upgrade the desk audit function are discussed in the following sections of this chapter.

INTERMEDIARIES THAT MADE BOTH DETAILED DESK AUDITS AND TENTATIVE SETTLEMENTS

Of the 13 intermediaries, nine made desk audits with the objective of identifying obvious errors and inconsistencies in cost reports and also made tentative settlements with hospitals. The principal causes of delays experienced by these nine intermediaries in completing desk audits and

making tentative settlements were (1) the need for additional information from hospitals to complete or correct cost reports and (2) the lack of sufficient staff to perform all required desk audits during peak workloads.

Because of these problems, significant backlogs of unaudited cost reports applicable to either the first or second reporting periods developed for six of the nine intermediaries. Further, for two of the nine intermediaries, these backlogs developed with respect to the third reporting period. The status at selected dates of desk audits for first-, second-, and third-year cost reports for these nine intermediaries is shown in the following table.

	Cost reports received	Desk audits completed	Backlogs
First-year cost reports:			
March 31, 1968	843	701	142
September 30, 1968	1,055	954	101
Second-year cost reports:			
March 31, 1969	813	557	256
September 30, 1969	1,081	944	137
Third-year cost reports:			
March 31, 1970	1,178	1,014	164

Return of incorrect cost reports to hospitals

Of the 701 first-year cost reports for which desk audits were completed at March 31, 1968, 211 were completed within 15 days after receipt of the cost reports. The remaining 490 desk audits required more than 15 days to complete, and, depending upon the intermediary, the average time between receipt of the cost report and completion of the desk audit ranged from about 1 month to 3 months.

Of these 490 cost reports, it was necessary to return 196 reports to the hospitals as unacceptable or to hold them until additional information was received from the hospitals. Further, 40 of the 142 cost reports for which desk audits were not completed at March 31, 1968, had been returned to hospitals for correction or were being held pending receipt of additional information from the hospitals.

Insufficient intermediary staff

Officials of seven of the nine intermediaries advised us that insufficient staff contributed to delays in making desk audits and tentative settlements. For example, all 105 hospitals serviced by one intermediary had fiscal years ending June 30. Therefore all cost reports were due at the same time. Our review of the intermediaries' records showed that, for desk audits that were completed at March 31, 1968, the average period of time between receipt of the cost report and completion of the desk audit was about 2 months. In May 1968 officials of this intermediary advised us that the same organizational group that performed desk audits also assisted hospitals in adapting their accounting systems to meet Medicare cost-reporting requirements and that the intermediary's six-man staff was not large enough to perform both functions.

At March 31, 1968, another intermediary, servicing about 320 hospitals during the first reporting period, had received 103 first-year cost reports of which 85 had been desk audited. For 66 of these reports (including 11 reports rejected by the intermediary), the time between receipt of the cost report and completion of the desk audit averaged about 2 months. In April 1968 officials at this intermediary advised us that only five of the 12 positions authorized for the hospital reimbursement department had been filled, which was the principal reason for the delays in completing desk audits.

INTERMEDIARIES THAT DID NOT MAKE BOTH DETAILED DESK AUDITS AND TENTATIVE SETTLEMENTS

Our review showed that four intermediaries had not followed the regular settlement process with respect to desk audits and tentative settlements.

One intermediary, servicing about 60 hospitals, did not return cost reports to hospitals after making desk audits but, rather, made Medicare field audits at hospitals with its own staff. Because these field audits usually started within a month after receipt of the cost reports, and sometimes even before cost reports were received, this intermediary handled its desk audits and field audits as virtually the same function. This approach expedited the overall settlement process.

Another intermediary, which serviced about 230 hospitals during the first reporting period, made desk audits and returned cost reports containing obvious errors or inconsistencies to hospitals or held such reports pending receipt of additional information. Generally, however, it did not make tentative settlements with hospitals for the initial accounting periods, because, even after desk audits, intermediary personnel had doubts concerning the accuracy of the cost reports.

At March 31, 1968, this intermediary had returned to hospitals or was holding for further information 39 of its backlog of 46 unaudited cost reports. The length of time that had elapsed since these cost reports initially had been submitted by hospitals averaged about 4 months.

Two intermediaries, which serviced about 540 and 185 hospitals, respectively, during the first reporting period, made only superficial desk audits for the first-year cost reports. Officials of both intermediaries advised us that detailed desk audits of cost reports had not been made because of a lack of staff. Further, tentative settlements were not made with a hospital unless it had requested that it be paid the amount due or unless it had submitted with its cost report a check for the indicated amount due to the Medicare program. Both these intermediaries subcontracted

the field audit function to public accounting firms and relied on the firms' field audits as a basis for identifying and correcting deficiencies in cost reports.

As discussed in the following chapter of this report, intermediaries often experienced extensive delays in initiating field audits. We believe that such delays, coupled with the failure to identify cost reports containing obvious errors or inconsistencies, tended to increase the amount of time needed to complete field audits, because, with the passage of time, deficiencies in cost reports became more difficult to resolve.

STEPS TAKEN BY SSA TO UPGRADE DESK AUDIT FUNCTION

In July 1968 SSA recommended to its intermediaries that they reduce the number and scope of field audits of cost reports. The purposes of this recommendation were to reduce auditing costs and to expedite the settlement process. To implement this policy, SSA advised the intermediaries that, in determining the number and scope of field audits to be made, it would be necessary for them to make analytical desk audits of cost reports, giving consideration to the results of prior years' field audits.

In August 1969 SSA furnished intermediaries with a detailed audit program for making desk audits of hospital cost reports to assist them in deciding whether there was a need for field audits of particular hospital cost reports.

In August 1970 SSA placed further importance on the desk audit function by instructing its intermediaries that, in every case in which a field audit was to be scheduled, its scope should be determined by the intermediary on the basis of a comprehensive desk audit of the cost report.

CONCLUSIONS

The major cause of the delays in making desk audits of Medicare cost reports was the lack of adequate intermediary staff. Because of the increased importance being placed by SSA on the desk audit step of the settlement process, we believe that SSA should carefully review the staffing

requirements of intermediaries. Where staffing problems continue, SSA should require BCA to assign high priority to resolving such problems.

RECOMMENDATION TO THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE

We recommend, therefore, that the Secretary of HEW, through SSA, require BCA to render more assistance to individual Blue Cross Plans in obtaining and training staff needed for making desk audits of provider cost reports.

AGENCY COMMENTS AND ACTIONS

In its July 14, 1970, letter to SSA commenting on our draft report, BCA stated that it supported our recommendation and that it had initiated action in the area of staff recruitment. HEW's September 28, 1970, letter to us also inidcated concurrence with our recommendation. HEW stated that, since November 1969, SSA had been closely monitoring intermediaries' provider reimbursement and audit activities with particular emphasis on ensuring that intermediaries had sufficient trained in-house staffs to make desk audits of cost reports.

CHAPTER 5

DELAYS BY INTERMEDIARIES IN MAKING FIELD AUDITS OF HOSPITAL COSTS

The third step of the settlement process involves field audits of hospital accounting records and related statistical data supporting the cost reports.

SSA instructions provide that all hospital cost reports be subject to audit. In April 1967 SSA instructed its intermediaries that, regardless of the amount of Medicare reimbursement, all hospital first-year cost reports for periods ending September 30, 1966, and later should be audited. In September 1967 SSA modified these instructions to provide that, if the annual rate of Medicare reimbursement was under $25,000 for a given period, a field audit would not be required for that period if, in the intermediary's judgment, such an audit would not be necessary.

In July 1968 SSA further modified its instructions and recommended that the number and scope of field audits be limited on the basis of (1) the intermediary's prior experience with a hospital's cost reports and (2) the analytical desk audits of the cost reports. For the first three Medicare cost-reporting periods (periods ending on or before June 30, 1967, 1968, and 1969), about 98 percent of the hospital cost reports included in our review were scheduled for field audits.[1]

DELAYS IN STARTING FIELD AUDITS

The graph on page 58 shows for the 2-1/2-year period from March 31, 1968, through September 30, 1970, the comparative progress of the 13 intermediaries included in our

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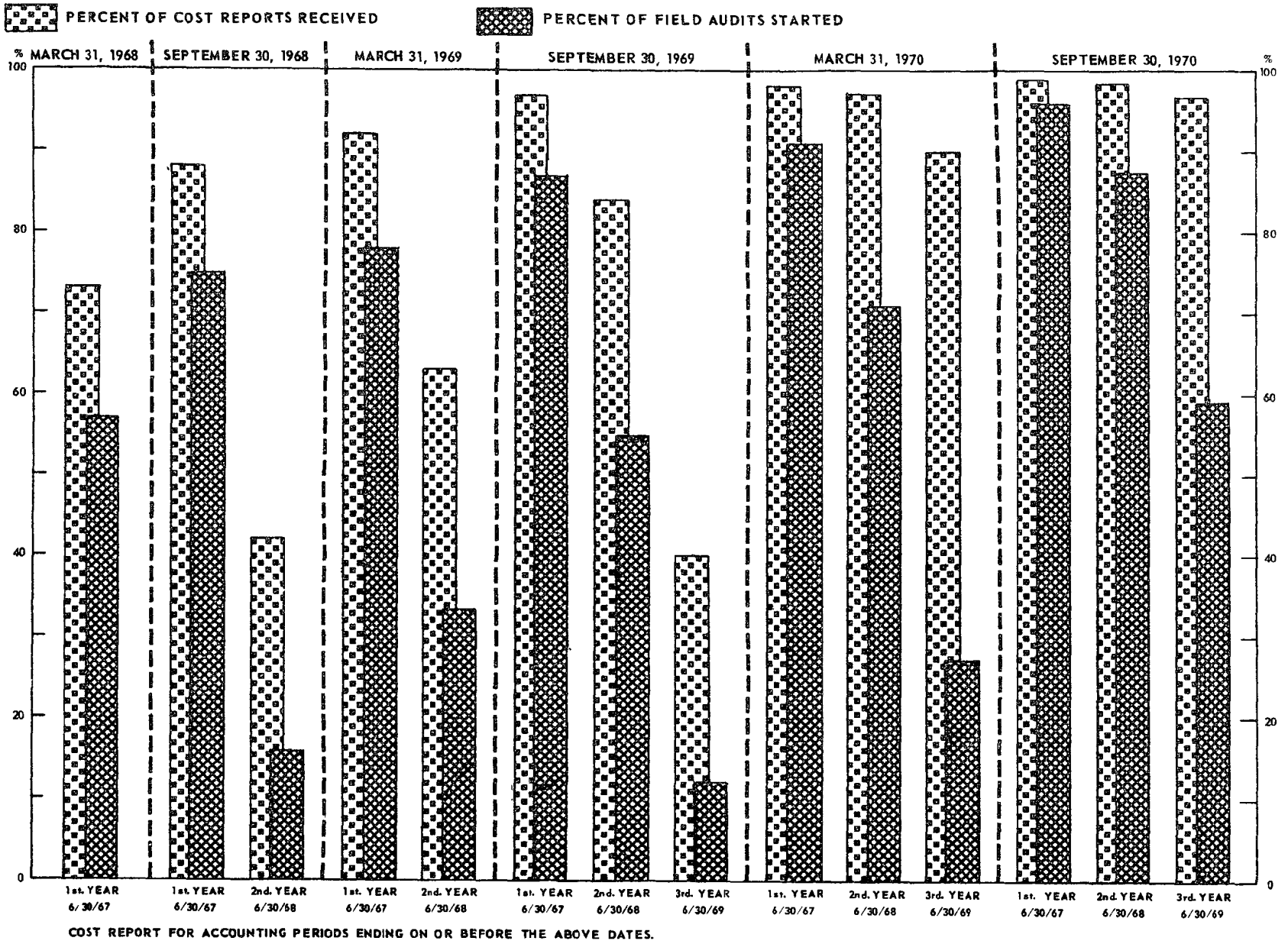
[1] In August 1970 SSA advised its intermediaries that, because of fund limitations for provider audit activities during fiscal year 1971, only about one third of the cost reports for which field audits had not started at that time could be undertaken. Similar restrictions were imposed on the number of field audits to be started for cost reports to be received during fiscal year 1971 (fourth and fifth year reports).


PERCENT OF COST REPORTS RECEIVED
PERCENT OF FIELD AUDITS STARTED
% MARCH 31, 1968
SEPTEMBER 30, 1968
MARCH 31, 1969
SEPTEMBER 30, 1969
MARCH 31, 1970
SEPTEMBER 30, 1970
%
100
80
60
40
20
0
1st. YEAR 6/30/67
1st. YEAR 6/30/67
2nd. YEAR 6/30/68
1st. YEAR 6/30/67
2nd. YEAR 6/30/68
1st. YEAR 6/30/67
2nd. YEAR 6/30/68
3rd. YEAR 6/30/69
1st. YEAR 6/30/67
2nd. YEAR 6/30/68
3rd. YEAR 6/30/69
1st. YEAR 6/30/67
2nd. YEAR 6/30/68
3rd. YEAR 6/30/69
COST REPORT FOR ACCOUNTING PERIODS ENDING ON OR BEFORE THE ABOVE DATES.

review in starting field audits for the first three reporting periods in relation to the number of cost reports received. As of September 30, 1970, or over 3 years after the end of the first reporting period, field audits of first-year cost reports were not started for about 4 percent of the hospitals included in our review. At that date, or over 2 years after the end of the second reporting period, field audits of second-year cost reports were not started for about 13 percent of the hospitals.

Further, as indicated by the graph, there was no improvement with regard to starting field audits between the first reporting period and the second and third reporting periods. For example, at September 30, 1968, field audits were not started for about 14 percent of the first-year cost reports that had been received. By comparison, as of September 30, 1969, field audits were not started for about 35 percent of the second-year cost reports received, and, as of September 30, 1970, field audits were not started for about 40 percent of the third-year cost reports received.

Methods of making field audits

Intermediaries made field audits by essentially two methods. For first-year cost reports, three of the 13 intermediaries included in our review, which serviced a total of about 190 hospitals, made field audits primarily with their own staffs (in-house).[1] The remaining 10 intermediaries primarily subcontracted with public accounting firms to make field audits.

For second-year cost reports, one of the three intermediaries that had made about 75 percent of the first-year hospital audits in-house subcontracted for about 85 percent of its second-year hospital audits because of the backlog of first-year cost reports to be audited by the intermediary's staff. On the other hand, two intermediaries which

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[1]One of the three intermediaries which serviced about 105 hospitals subcontracted for about 25 percent of its first-year hospital field audits.

serviced about 465 hospitals and had subcontracted about 90 percent of their first-year field audits, made about 45 percent of the field audits of second-year cost reports in-house.

For the third-year cost reports, the trend toward making in-house field audits continued. The intermediary that had changed from in-house to subcontracted field audits for the previous year's reports changed back to making field audits primarily in-house. The two intermediaries which serviced 465 hospitals and which had made about 45 percent of their second-year hospital audits in-house made about 50 percent of their field audits of third-year cost reports with their own staffs. Also, for third-year cost reports, another intermediary, which serviced 22 hospitals, changed from subcontracting field audits to making about 70 percent of the audits in-house.

In summary, for the 13 intermediaries included in our review, about 10 percent of the field audits of first year cost reports were made in-house; about 15 percent of the field audits of second-year cost reports were made in-house; and about 25 percent of the field audits of third-year cost reports were made in-house.

Although delays in starting field audits were encountered under both methods, we noted that those intermediaries that had made field audits primarily with their own staffs had made substantially better progress in reducing the backlogs of field audits to be started than those intermediaries that had subcontracted most of their field audits. The following table shows the comparative progress in starting first-year field audits by the three intermediaries that made such audits in-house and by the 10 intermediaries that primarily subcontracted the field audit functions.

First-Year Cost Reports Received and Field Audits Started

As of	Cost reports received (note a)		Field audits started		Backlog		Backlog as a percent of cost reports received	
	In-house	Sub-contract	In-house	Sub-contract	In-house	Sub-contract	In-house	Sub-contract
Mar. 31, 1968	155	1,426	112	1,140	43	286	27.7	20.1
Sept. 30, 1968	174	1,752	172	1,488	2	264	1.1	15.1
Mar. 31, 1969	187	1,845	185	1,557	2	288	1.1	15.6
Sept. 30, 1969	187	1,964	186	1,760	1	204	.5	10.4
Mar. 31, 1970	187	1,994	187	1,865	-	129	-	6.5
Sept. 30, 1970	187	2,010	187	1,948	-	62	-	3.1

[a]Excludes cost reports for which intermediaries determined that field audits were not necessary.

Delays in starting field audits made by intermediary staffs

The primary cause for delays in starting field audits by the staffs of the intermediaries was an uneven audit work load resulting from many hospitals having the same cost-reporting periods.

Of the three intermediaries that made first-year hospital audits with their own staffs, one intermediary which serviced about 60 hospitals did not encounter any delays in starting field audits for the first three reporting periods. This intermediary generally started field audits within a month after receipt of the cost reports and, in some instances, even before cost reports were received. For the first reporting period, virtually all hospital cost reports were due by March 31, 1967. Because of delays in submission of cost reports, however, no more than seven reports were received by the intermediary during any of the next 12 months. Therefore, a backlog of unaudited cost reports did not develop. Similar conditions existed for both the second and third reporting periods.

The two other intermediaries that initially made field audits with their own staffs were delayed in starting field audits because many of the hospitals which they serviced had identical reporting periods. For example, for one intermediary, the lapse of time between the completion of desk audits and the start of field audits averaged about 5 months. This intermediary serviced 23 hospitals of which 19 had a reporting period ending December 31. Of these cost reports, 15 had been received and had had desk audits completed by June 30, 1967, which, in turn, created a scheduling problem for the intermediary's field audit staff.

Similar backlogs developed for the second and third reporting periods. For example, at March 31, 1969, or a year after the second-year cost reports were due, the intermediary had received 20 second-year cost reports but had not started field audits of seven reports. At March 31, 1970, the intermediary had received 22 third-year cost reports but had not started field audits of 15 reports.

Delays in starting field audits under subcontracts with public accounting firms

SSA's contract with BCA provided that audit subcontracts with public accounting firms be subject to approval by SSA. The 10 intermediaries included in our review, which had initially subcontracted for this service, awarded subcontracts of about $6 million to public accounting firms for field audits of hospital cost reports for the first reporting period.

We noted that these intermediaries that had subcontracted for field audits could be divided into two general categories. One group--four intermediaries servicing about 605 hospitals during the first three reporting periods--assigned[1] cost reports for field audits prior to SSA approval of the audit subcontracts, although such approval was eventually obtained.

The second group--six intermediaries, servicing about 1,450 hospitals during the first reporting period and about 1,530 hospitals during the second and third reporting periods--generally did not assign cost reports to public accounting firms for field audits until the audit subcontracts had been approved by SSA. Delays in starting field audits were usually longer for intermediaries in the second group.

For example, at March 31, 1968, the four intermediaries that had made audit assignments before SSA approval of the audit subcontracts completed desk audits of 425 first-year cost reports and assigned 350 of these reports for field audits. About 80 percent of these audit assignments were made within 2 weeks after completion of the intermediaries' desk audits. For 3 of the 4 intermediaries, Medicare field audits were made by the audit subcontractors simultaneously with field audits of cost reimbursements under the Blue Cross commercial insurance programs.

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[1] An assignment means that the intermediary had forwarded the cost report to the public accounting firm with instructions to start the field audit.

In contrast, at March 31, 1968, the six intermediaries that did not make field audit assignments before SSA approved the audit subcontracts completed desk audits of 885 first-year cost reports and assigned 790 of these reports for field audits. Only about 35 percent of the audit assignments were made within 2 weeks after completion of the desk audits. A principal cause of the intermediaries' delays in starting field audits was the difficulty in obtaining SSA approval of the audit subcontracts.

The primary reasons given by SSA for initially refusing to approve intermediaries' audit subcontracts were that (1) proposed average rates of compensation, which ranged as high as $116 a day, were considered excessive, (2) estimates of time required to make audits were too high, (3) estimates for travel and/or incidental expenses were too high, and (4) certain deviations from the wording and format of the prescribed model subcontract were unacceptable to SSA. As shown by the following examples, difficulties in obtaining SSA approval of audit subcontracts contributed to delays in starting field audits of first-year cost reports.

One intermediary, servicing about 160 hospitals during the first reporting period, completed desk audits of about 40 first-year cost reports in March and April 1967. The audit subcontracts, however, were not approved by SSA until July, August, and October 1967, which caused delays of from 4 to 6 months in assigning these cost reports for field audits. Another intermediary, servicing about 180 hospitals during the first reporting period, completed its desk audits of about 60 cost reports in June and July 1967; however, its audit subcontracts were not approved until September and October 1967, which resulted in delays of about 3 months in assigning these cost reports for field audits.

Delays resulting from difficulties in negotiating acceptable audit subcontracts extended beyond the first reporting period. For example, in March 1969 SSA had not approved audit subcontracts for second-year cost reports for five of the 10 intermediaries that subcontracted for audit services for the first-year reports. These audits were to be made at hospitals that had cost-reporting periods that ended between July 1, 1967, and June 30, 1968. Two of the

five intermediaries generally did not assign cost reports for field audits until the audit subcontracts had been approved by SSA. At March 31, 1969, these two intermediaries received about 175 second-year cost reports but field audits were started on only 19.

Steps taken by SSA to reduce delays in starting field audits

In April 1969 SSA advised its intermediaries to develop at least a limited in-house capability for making field audits. SSA pointed out that such a capability would facilitate the implementation of limited-scope audits, as well as the administration of audit subcontracts.

In August 1970 SSA instructed its intermediaries to encourage hospitals to submit cost reports that were certified as accurate by hospitals' independent auditors. Although these certified cost reports would be subject to the same comprehensive desk audits as other cost reports, SSA advised its intermediaries that such certified cost reports normally should not be scheduled for field audits. If SSA's new policy is successful, the field audit step of the settlement process, as it was administered during the period covered by our review, would be changed significantly and its delaying effect would be minimized considerably.

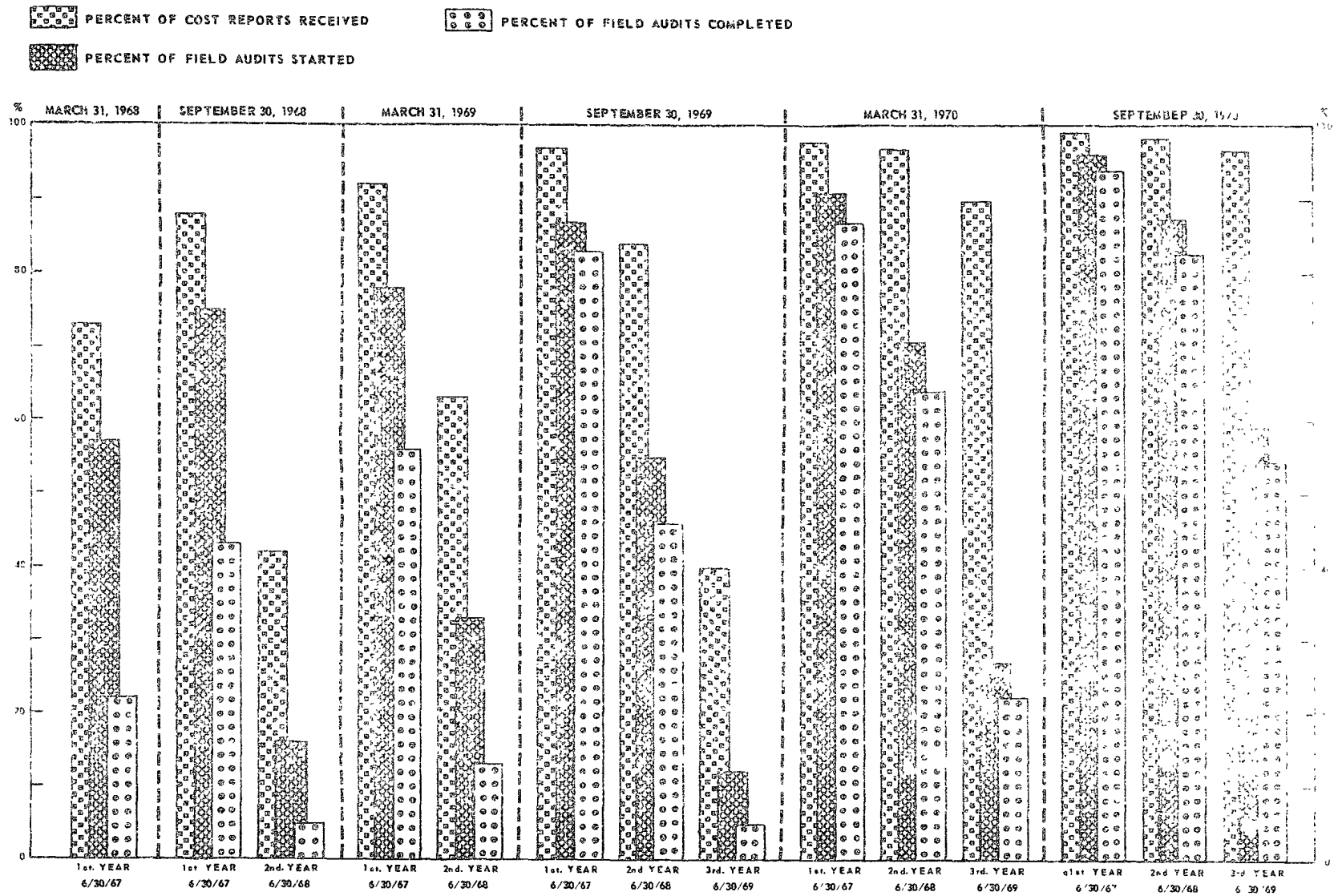
DELAYS IN COMPLETION OF FIELD AUDITS

The SSA model subcontract for use by intermediaries in obtaining audit services provides that the accounting firm furnish a written audit report to the intermediary within 3 months from the date that the firm receives the cost report from the intermediary. The subcontract provides also that this period may be extended by agreement between the intermediary and the accounting firm. For the intermediaries included in our review, about one third of the first-year audits performed under subcontracts were completed within the 3-month period.

The graph on page 66 shows for the 2-1/2-year period from March 31, 1968, through September 30, 1970, the comparative progress in completion of field audits by the 13 intermediaries for the first three cost-reporting periods in relation to the number of field audits started and the number of cost reports received. At September 30, 1970, over 3 years after the end of the first reporting period, about 6 percent of the first-year field audits were not completed. At that date, over 2 years after the end of the second reporting period, about 17 percent of the field audits were not completed for second-year cost reports.

As indicated by the graph, however, there has been progressive improvement in completing field audits for the first, second, and third reporting periods. For example, at September 30, 1968, of the 1,660 first-year field audits started, 706, or about 43 percent, were not completed. At the comparable time applicable to the second reporting period (September 30, 1969), of the 1,259 field audits started, 191, or about 15 percent, were not completed. At the comparable time applicable to the third reporting period (September 30, 1970), of the 1,345 field audits started, 106, or only about 8 percent, were not completed.

As indicated on page 60, for the first, second, and third reporting periods, the proportion of field audits made by the intermediaries' staffs progressively increased. Overall, however, about 85 percent of the field audits for the first three reporting periods were subcontracted to public accounting firms.


PERCENT OF COST REPORTS RECEIVED
PERCENT OF FIELD AUDITS COMPLETED
PERCENT OF FIELD AUDITS STARTED
%
100
50
0
MARCH 31, 1968
SEPTEMBER 30, 1968
MARCH 31, 1969
SEPTEMBER 30, 1969
MARCH 31, 1970
SEPTEMBER 30, 1970
1st. YEAR 6/30/67
1st YEAR 6/30/67
2nd. YEAR 6/30/68
1st. YEAR 6/30/67
2nd. YEAR 6/30/68
1st. YEAR 6/30/67
2nd YEAR 6/30/68
3rd. YEAR 6/30/69
1st. YEAR 6/30/67
2nd. YEAR 6/30/68
3rd. YEAR 6/30/69
1st YEAR 6/30/67
2nd YEAR 6/30/68
3rd YEAR 6/30/69
COST REPORT FOR ACCOUNTING PERIODS ENDING ON OR BEFORE THE ABOVE DATES

Delays in completing field audits under subcontracts with public accounting firms

Some of the causes cited to us by intermediaries and public accounting firms as contributing to delays in the completion of subcontracted field audits were (1) the lack of action by the intermediaries to enforce contract provisions concerning completion of audits and (2) the reluctance of public accounting firms to render the type of opinion that they believed was required by SSA instructions regarding certification of the accuracy of specific items on cost reports.

In addition to the foregoing causes, which were specifically applicable to the field audit step of the settlement process, delays were also caused by inadequacies in hospital accounting systems which caused problems in verifying the information shown on the cost reports to hospital accounting records (see ch. 3) and by the unwillingness of hospitals to accept audit adjustments and/or to prepare revised cost reports (see ch. 6). In some instances intermediary officials cited two or more reasons for delays in completing subcontracted field audits.

Subcontract provisions not enforced

The 10 intermediaries that subcontracted with accounting firms for the audits of first-year cost reports generally did not enforce the provision in the audit subcontracts that field audits be completed and a written report submitted to the intermediary not later than 3 months after receipt of a cost report by the accounting firm. Officials at six intermediaries, servicing about 1,210 hospitals during the first reporting period, advised us that less-than-standard rates were negotiated with the public accounting firms with the understanding that the intermediaries would not require that Medicare audits be given top priority during the accounting firms' busy season.

The accounting firms advised us that their delays in completing the audits resulted, in part, from the lack of timely advice from the intermediaries regarding interpretations of the SSA reimbursement principles.

Problems in obtaining opinions
on cost reports from public accounting firms

The SSA model audit subcontract provides that independent audits of hospital costs be made by public accounting firms in accordance with generally accepted standards applicable in the circumstances. Such audits, as a minimum, must meet the requirements of the audit instructions and guidelines issued by the Secretary of HEW.

The initial audit instructions issued in June 1966, as well as the cost report forms issued in September 1966, included a pro forma certification to be used by the accounting firm in rendering an unqualified opinion attesting to the accuracy of the cost report in conformance with the SSA principles of reimbursement. The pro forma certification for an unqualified opinion made specific reference to certain data shown on cost reports, such as inpatient-days and occasions of service in the outpatient department, because SSA considered such data valuable in developing program statistics. The instructions also included certain pro forma language for rendering a qualified opinion or no opinion.

The public accounting profession objected to highlighting certain specific data in the certification because it implied a degree of accuracy of such data which was not warranted by the scope of the audits. In June 1967 SSA issued revised guidelines to intermediaries, which changed the pro forma certification to conform to language suggested by the American Institute of Certified Public Accountants.

As much as a year later, five intermediaries, which serviced about 965 hospitals during the first reporting period, and/or their subcontractors were apparently not aware of the June 1967 changes because corresponding changes had not been made in the cost report forms. For example, three intermediaries, servicing about 550 hospitals, started about 330 field audits before March 31, 1968, for which only one was completed at that time. These audits were assigned or in process for an average of about 6 months. Intermediary officials and officials of the accounting firms advised us in May and June 1968 that a major cause of delays involved disagreements concerning the format of the auditors' certification which had been changed by SSA to meet the accounting profession's objections about a year earlier.

CONCLUSIONS AND AGENCY COMMENTS

For those intermediaries making field audits principally with their own staffs, a major cause of the delays in starting the field audits was the uneven distribution of the intermediaries' workloads resulting from many hospitals serviced by a particular intermediary having the same Medicare reporting period. Our recommendation providing for a more even distribution of intermediaries' workload by encouraging certain hospitals to change their Medicare reporting period and HEW's comments thereon are discussed in chapter 3.

For intermediaries subcontracting the field audit functions, major causes of delays in starting and completing field audits included (1) difficulties in obtaining SSA approval of the audit subcontracts and (2) the lack of action by the intermediaries to enforce the contract provision concerning the timely completion of field audits. Partially because of these problems with subcontracted field audits, a number of intermediaries progressively increased the proportion of field audits made by their own staffs (in-house) for the second and third reporting periods.

In commenting on the delays in making field audits, HEW, in its September 28, 1970, letter to us, pointed out that over 40 of the 74 Blue Cross Plans and half of the commercial intermediaries were making some field audits with their own staffs. HEW also stated that (1) the intermediaries had substantially increased the number of limited-scope audits and (2) SSA's August 1970 instructions to the intermediaries had given new emphasis to the no-audit/limited-scope-audit approach by requiring more final settlements to be made without field audits.

SSA's August 1970 instructions provided for a significant departure from the settlement process as it was carried out during the period covered by our review in that as many as two thirds of the settlements with hospitals may be made without any field audits. These instructions provide, however, that hospital cost reports for which settlements have been made be subject to an intermediary audit and appropriate adjustment within 3 years from the time that a cost report is due to be submitted or is submitted to the intermediary.

Because the foregoing changes in the field audit step of the settlement process had not been implemented at the time of our field reviews, we did not evaluate the overall effect of such changes on settlements with hospitals. Therefore we are making no specific recommendations with respect to the field audit function at this time.

CHAPTER 6

DELAYS IN MAKING FINAL SETTLEMENTS WITH HOSPITALS

The HEW contract with BCA and the BCA subcontracts with Blue Cross Plans provide that intermediaries make final, annual determinations of the amount of payment to be made to each hospital for the reasonable cost of services furnished to eligible Medicare beneficiaries. These final settlements by Blue Cross Plans which complete the settlement process are subject to review and concurrence by BCA.

The HEW contract with BCA also provides that BCA establish and maintain an appeals procedure for resolving any payment dispute arising between a hospital and a Blue Cross Plan. The BCA appeals procedures is in addition to any mechanisms of the local Blue Cross Plans for handling such disputes.

During the period of our review, no appeals mechanism for resolving disputes over BCA payment determinations was available to hospitals or other providers.[1] As a matter of practice, however, through September 1970, the BCA appeals procedure was not used extensively by hospitals.[2] Final settlements usually were made on the basis of negotiations between local Blue Cross Plans and hospitals.

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[1] A provision in a bill (H.R. 17550), which was passed by the United States Senate on December 29, 1970, but which failed of enactment during the 91st Congress, would establish an appeals board to hear appeals on reimbursement decisions made by intermediaries such as BCA, under certain conditions, and where the amount at issue was $10,000 or more.

[2] For example, at September 30, 1969, the 13 intermediaries had a backlog of 1,833 audited first- and second-year cost reports for which final settlements had not been made; only nine of these 1,833 cost reports had been held up pending resolution of disputes through the BCA appeals procedure. At September 30, 1970, the 13 intermediaries had a backlog of about 2,350 audited first-, second-, and third-year cost reports for which final settlement was not made. At that time BCA had 14 hospital appeals in process.

The graph on page 73 shows for the 2-1/2-year period from March 31, 1968, through September 30, 1970, the comparative progress in completion of final settlements by the 13 intermediaries included in our review for the first three cost-reporting periods in relation to the previous steps in the settlement process. At September 30, 1970, or over 3 years after the end of the first reporting period, final settlements were not made with about 32 percent of the hospitals included in our review. At that date, or over 2 years after the end of the second reporting period, final settlements were not made with about 62 percent of the hospitals.

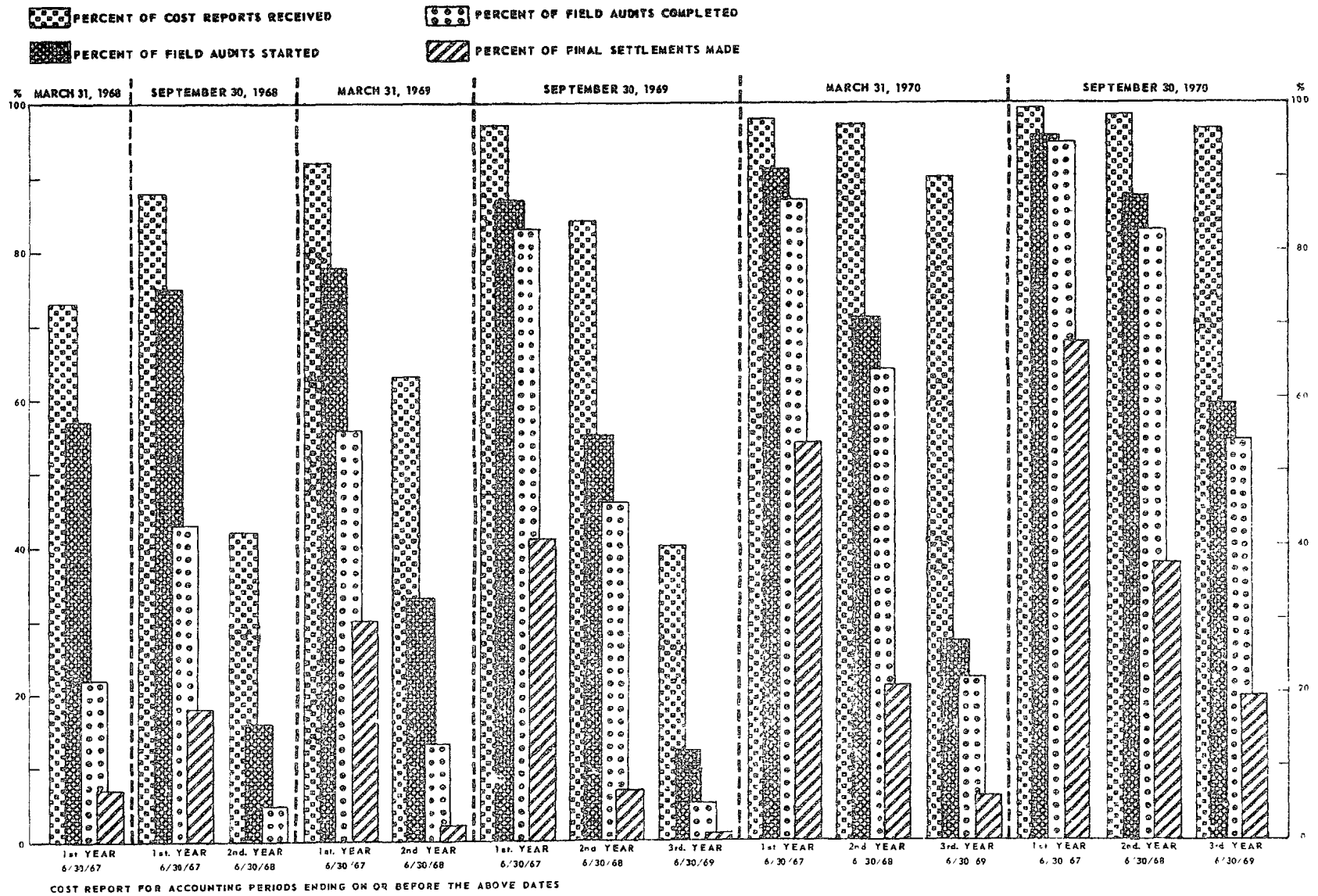
For those final settlements that had been made, SSA reported that about 88 percent had cleared the BCA review process and had been submitted to SSA for its review and use in developing program statistics, cost analyses, and cost estimates.

There was no improvement in making final settlements between the first reporting period and the second and third reporting periods. For example, at September 30, 1968, 954 field audits of first-year cost reports were completed; however, final settlements were not made for about 58 percent of these cost reports.

At the comparable time applicable to the second reporting period (September 30, 1969), 1,068 field audits of second-year cost reports were completed, but final settlements were not made for about 84 percent of these reports. At the comparable time applicable to the third reporting period (September 30, 1970), 1,239 field audits of third-year cost reports had been completed, but final settlements had not been made for about 65 percent of these reports.

CAUSES FOR DELAYS IN MAKING FINAL SETTLEMENTS

Officials of nine of the 13 intermediaries indicated that delays in making final settlements were due primarily to difficulties in obtaining hospitals' agreements to audit adjustments and in obtaining adjusted cost reports from the hospitals.


PERCENT OF COST REPORTS RECEIVED
PERCENT OF FIELD AUDITS COMPLETED
PERCENT OF FIELD AUDITS STARTED
PERCENT OF FINAL SETTLEMENTS MADE
% MARCH 31, 1968
SEPTEMBER 30, 1968
MARCH 31, 1969
SEPTEMBER 30, 1969
MARCH 31, 1970
SEPTEMBER 30, 1970
%
100
80
60
40
20
0
1st YEAR 6/30/67
1st. YEAR 6/30/67
2nd. YEAR 6/30/68
1st. YEAR 6/30/67
2nd YEAR 6/30/68
1st. YEAR 6/30/67
2nd YEAR 6/30/68
3rd. YEAR 6/30/69
1st YEAR 6/30/67
2nd YEAR 6 30/68
3rd. YEAR 6/30 69
1st YEAR 6/30 67
2nd. YEAR 6/30/68
3rd YEAR 6/30/69
COST REPORT FOR ACCOUNTING PERIODS ENDING ON OR BEFORE THE ABOVE DATES

For example, at September 30, 1969, two intermediaries in one State, which serviced about 550 hospitals during the first reporting period and about 580 hospitals during the second reporting period, had 329 first-year and 78 second-year field audits completed. These intermediaries, however, had made settlements for only 49 first-year and 14 second-year cost reports. According to SSA these two intermediaries attributed the backlogs of audited cost reports for which settlements had not been made to the failure of hospitals to submit adjusted cost reports and to the Plans' lack of authority to require hospitals to submit revised cost reports.

In August 1969, however, SSA issued instructions to intermediaries, which were designed to simplify the revision of the reports to consider minor adjustments without requiring that a revised cost report be prepared in entirety.

STEPS TAKEN BY BCA TO MAKE FINAL SETTLEMENTS WITHOUT AGREEMENTS WITH HOSPITALS

To reduce backlogs of audited cost reports for which settlements had not been made, BCA, in April 1969, advised local Blue Cross Plans that, if hospitals delayed in submitting revised cost reports, the Plans should prepare corrected reports. Further, if hospitals did not agree with audit adjustments, local Plans were instructed by BCA to (1) prepare revised cost reports incorporating proposed adjustments and (2) give the hospitals an opportunity to submit statements outlining their objections. Final settlements could then be made by the local Plans on the basis of adjusted reports, and hospitals could file appeals with the local Plans. As stated previously, concurrence by a hospital or other provider is not necessary for an intermediary to make a final settlement.

The following table shows that, between March 31, 1969, and September 30, 1970, a solution had not been found to the problem of reducing the backlogs of audited first- and second-year cost reports for which settlements had not been made. These statistics indicated to us that issuance of BCA's April 1969 instructions had not materially reduced delays in making final settlements.

	March 31, 1969			September 30, 1970		
	Total	First-year cost reports	Second-year cost reports	Total	First-year cost reports	Second-year cost reports
Field audits completed	1,550	1,252	298	3,977	2,092	1,885
Final settlements made	716	671	45	2,395	1,522	873
Backlog	834	581	253	1,582	570	1,012
Backlog as a percent of field audits completed	53.8	46.4	84.9	39.8	27.2	53.5

CONCLUSIONS

We believe that there is a need for more direct BCA involvement with those local Blue Cross Plans having acute problems with final settlement backlogs. For those Plans having particular difficulties in making final settlements, we believe that, after field audits have been completed, providers should be given reasonable time limits within which to submit adjusted cost reports. If providers fail to meet these deadlines, we believe that BCA should prepare the adjusted cost reports and should notify the providers that the amount of final settlements had been determined. We believe also that appeals of such BCA determinations should be made directly to BCA rather than to the local Plans.

RECOMMENDATION TO THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE

We recommend that the Secretary of HEW, through SSA require BCA to take a more active role in the final settlement process by directly assisting those local Blue Cross Plans that have the most serious backlogs of audited cost reports for which settlements have not been made.

AGENCY COMMENTS AND ACTIONS AND GAO EVALUATION

In its July 14, 1970, letter to SSA commenting on our draft report, BCA indicated that during 1969 it had issued or had participated in SSA's issuance of certain instructions to the local Plans which were designed to resolve the backlog problem. Most of the 1969 instructions cited by BCA have been mentioned previously in this report, but, as

shown by the graph on page 73, as of September 30, 1970, the backlog of audited cost reports for which settlements were not made continued to exist. This backlog indicates to us that further actions are necessary.

In its September 28, 1970, letter to us commenting on our recommendations, HEW advised us that BCA did not have sufficient staff to become directly involved in individual provider cost settlements. HEW stated also that BCA's role in its relations with the individual Plans under the Medicare program was an administrative, rather than an operative, one.

In our opinion, the role of BCA under its prime contract with HEW should be to require performance from its subcontractors (the local Plans) or to take such other steps as may be necessary to fulfill its contractual obligations. Such steps could include taking the initiative in assisting certain Plans in making settlements with individual providers, particularly where such settlements at a particular Plan had been consistently delayed for unduly long periods of time.

CHAPTER 7

DELAYS IN SETTLEMENT PROCESS FOR ECFs

The causes of delays in the preparation of hospital cost reports and in the settlement process for hospitals have been discussed in preceding chapters. Although there are variances between the cost-reporting formats for ECFs and hospitals, the reimbursement principles and the steps usually followed in the settlement process are the same. Medicare benefits for hospital services, however, became effective on July 1, 1966; whereas coverage for ECF services became effective on January 1, 1967, or 6 months later.

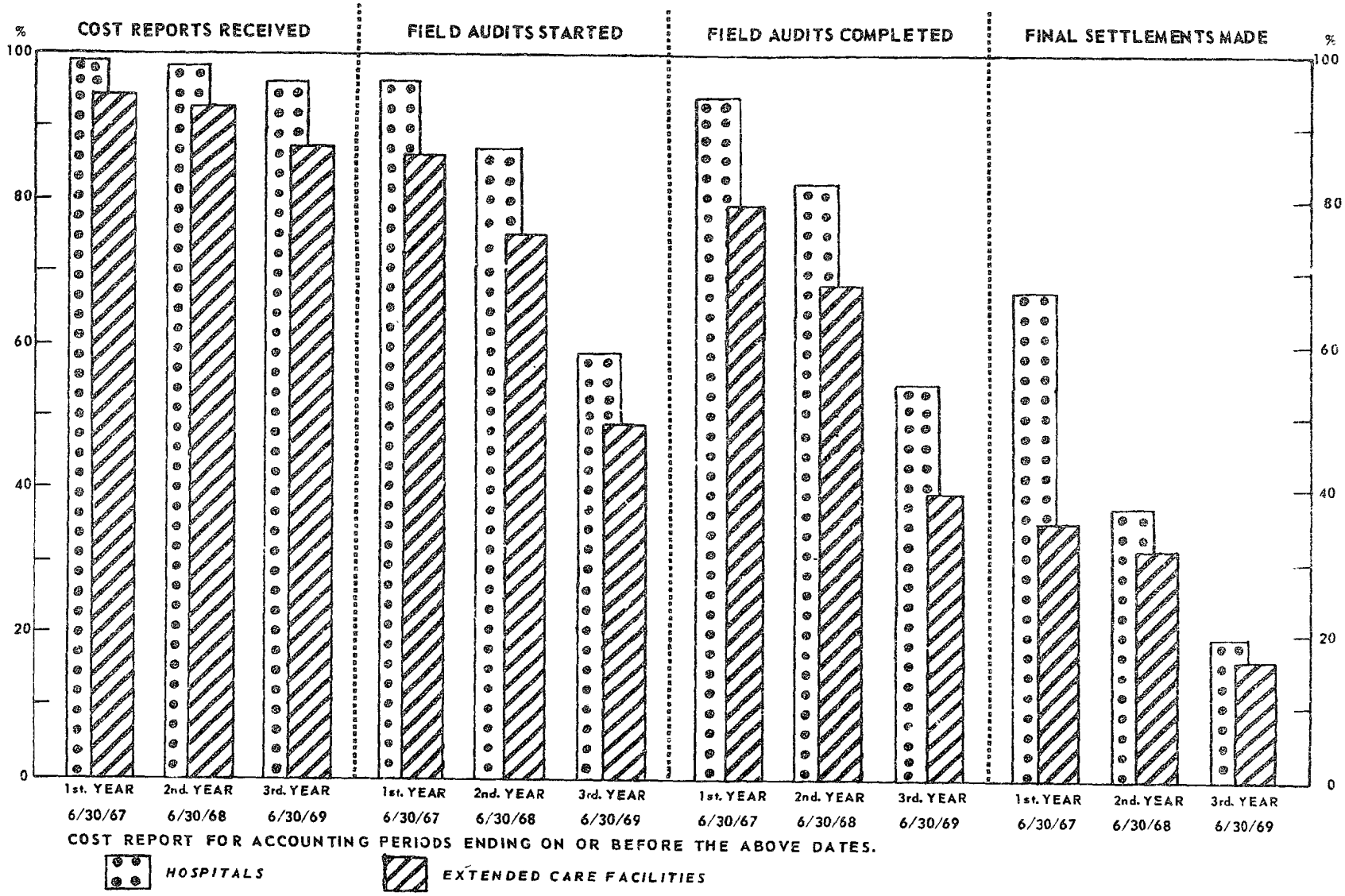
At September 30, 1970, the 13 intermediaries included in our review were responsible for making about 300 first-year ECF settlements, about 985 second-year ECF settlements, and about 1,140 third-year ECF settlements. As shown by the graph on page 78, the progress made by these 13 intermediaries in the various steps of the settlement process for the first three reporting periods under the program was comparatively slower for the ECFs than for the 2,245 hospitals for the first year and the 2,325 hospitals for the second and third years serviced by these 13 intermediaries. At September 30, 1970, final settlements were made with about 33 percent of the ECFs for their first- and second-year cost-reporting periods and with about 16 percent for their third-year reporting periods.

CAUSES FOR DIFFERENCES BETWEEN HOSPITAL AND ECF SETTLEMENTS

Some of the reasons why settlements with ECFs lagged behind settlements with hospitals for the first 2 years were that (1) ECFs had entered the program 6 months after hospitals, (2) SSA had not furnished intermediaries with cost report forms for ECFs until February 1968, and (3) intermediaries had assigned hospital audits and related settlements priority over ECF audits and settlements.

Because Medicare benefits for extended-care services became effective on January 1, 1967, or 6 months after hospital benefits became effective, only about 300 of the ECFs

COMPARATIVE STATUS OF SETTLEMENTS FOR HOSPITALS AND ECF's AS OF SEPTEMBER 30, 1970



serviced by the 13 intermediaries included in our review had reporting periods ended on or before June 30, 1967. Therefore many of the ECFs' initial cost reports would be shown as second-year settlements.

We noted that SSA had not furnished ECF cost report forms to intermediaries until February 1968, or at least 7 months after the end of the first reporting period for those ECFs having reporting periods ended on or before June 30, 1967, and several months after many of the ECFs having reporting periods ended on or before June 30, 1968, were supposed to have submitted initial reports.

Intermediary officials advised us that, because hospitals received about 90 percent of the benefit payments made under part A of the Medicare program, they had assigned audits and settlements with hospitals priority over audits and settlements with ECFs.

SPECIAL SIGNIFICANCE OF DELAYS IN SETTLEMENTS WITH ECFs

Although ECFs received only about 10 percent of the benefit payments made under part A, the delays in making settlements with ECFs assumed special significance because of the relatively large number of ECFs that had terminated participation in the program without having made settlements with intermediaries. By February 1969 about 700 ECFs had terminated.[1] A year later ECF terminations had increased

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[1] A termination can take various forms. In many instances, the termination takes the form of a change of ownership in that there is a change in the parties to the provider agreement with SSA, but the old provider could continue to operate the facility in the program under a new agreement. There also are voluntary terminations in which providers elect to cease to participate in the program and involuntary terminations in which SSA terminates its agreement with the provider, usually for failure to comply with the conditions for participation in the Medicare program.

to 1,700, and by December 1970 total ECF terminations has increased to 2,800.

Of the 700 ECF terminations by February 1969, about 150 had been under the jurisdiction of the 13 intermediaries included in our review. About one third, or 52, of these terminations had been under the jurisdiction of one intermediary. We selected a sample of 17 of these 52 terminations and found that, although these ECFs terminated participation in the program between July 1967 and October 1968, there were no final settlements made nor field audits completed by February 1970.

Of the 17 ECFs, 10 had not submitted cost reports for the reporting period preceding their terminations. Medicare payments to these 10 ECFs for the periods for which cost reports had not been submitted totaled about $400,000.

In view of the special significance of the delays in settlements with ECFs because of the large number of such institutions that have terminated their participation in the program, we are making a review to determine (1) the reasons why these providers left the program, (2) the extent that Medicare payments to terminated providers have not been accounted for because of delays in settlements, and (3) the extent and the reason for any overpayments made to terminated providers not having been recovered.

CHAPTER 8

CHANGES PROPOSED BY HEW IN METHODS OF REIMBURSEMENT TO PROVIDERS OF SERVICE

In testimony before the Senate Committee on Finance in February 1970, the Under Secretary of HEW proposed fundamental changes in the methods of reimbursing providers of service under the Medicare program. Such proposed changes are also applicable to the Medicaid program (State plans for medical assistance to indigent families and disabled individuals financed in part by Federal funds). These proposals, which would require changes in legislation, would provide for reimbursements to providers at rates established on a prospective basis with incentives for efficient management rather than on a retrospective, reasonable-cost basis.

The implementation of the Under Secretary's proposals for prospective reimbursements would practically eliminate the settlement process as it is described in this report and could involve such payment mechanisms as (1) preapproved budgets or schedules of charges developed by committees consisting of representatives of providers, Blue Cross Plans, private insurance companies, the public, and the Medicare and Medicaid programs, (2) establishment of target rates based, in part, on known patient-care costs for the past period, and (3) negotiations with classes of hospitals or other providers of comparable size and scope of service in given geographical areas.

These prospective payment methods could include certain features of the current retrospective settlement process to the extent that they involved (1) consideration of prior costs of providing services and (2) negotiations with individual providers.

If these matters cannot be handled more timely on a prospective basis than they have been handled on a retrospective basis, it can be expected that many of the problems discussed in this report will hamper the effective implementation of these proposals. In other words, if costs

cannot be estimated and agreed to prospectively on a more timely basis than costs have been determined and agreed to retrospectively, the prospective reimbursements could also represent payments for services long after they had been furnished and thereby could reduce incentives for more efficient management.

The Social Security Amendments of 1970 (H.R. 17550), which was passed by the House of Representatives on May 21, 1970, but which failed of enactment by the Ninety-first Congress, would authorize the Secretary of HEW to reimburse providers at rates established prospectively on an experimental basis only.

According to the report of the House Committee on Ways and Means (H. Rept. 91-1096) that accompanied the bill, the Committee was concerned about the possible disadvantages of the prospective reimbursement method, particularly because there was no assurance that the changes would result in the Government's reimbursing providers at levels lower, or even as low as, those which would result if the present retrospective cost-finding approach was continued. The Committee pointed out that a solid foundation of experience was required with all possible alternative forms of reimbursement before permanent changes were made.

The December 1970 report of the Senate Finance Committee (S. Rept. 91-1431) on the Social Security Amendments of 1970 expressed similar views regarding experimentation with prospective reimbursement methods. Although the Senate passed its version of the bill on December 29, 1970, it was not enacted into law before the expiration of the Ninety-first Congress.

On January 22, 1971, the Social Security Amendments of 1971 (H.R. 1) was introduced in the House of Representatives. In regard to the subject of authorizing the Secretary of HEW to reimburse providers prospectively on an experimental basis only, House bill 1 was similar to House bill 17550 which had been passed by the House of Representatives in May 1970.

Pending the legislative approval and implementation of the fundamental changes in the methods of reimbursing hospitals and ECFs as proposed by the Under Secretary of HEW,

we believe that the existing settlement process could be expedited with resultant savings in the costs of administering the Medicare program. In our opinion, unless improvements in the several steps of the settlement process are made, the amount of Medicare payments--amounting to billions of dollars--that have not been afforded an appropriate final accounting can be expected to increase, and reports to the agency and congressional bodies on Medicare reimbursements to institutions will not be based on the most current and accurate data.

CHAPTER 9

SCOPE OF REVIEW

Our review was made to determine the causes of delays in making final settlements of provider cost reimbursements under the Medicare program and included an evaluation of SSA's controls over the settlement process under its contract with BCA, the principal intermediary for the Medicare program.

The work was done at the SSA Central Office in Baltimore, Maryland; at BCA in Chicago, Illinois; and at 13 Blue Cross Plans, operating under subcontracts with BCA. These 13 Plans were located in Towson, Maryland; Syracuse and New York, New York; Newark, New Jersey; Pittsburgh, Pennsylvania; Cleveland and Youngstown, Ohio; Jacksonville, Florida; Dallas, Texas; Milwaukee, Wisconsin; Los Angeles and Oakland, California; and Chicago.

We reviewed the basic legislation establishing the Medicare program and the related regulations prescribed by the Secretary of HEW for the administration of this program. We also reviewed pertinent records, reports, and documents and interviewed officials of SSA, BCA, and the intermediaries concerning various aspects of the settlement process. We also examined into the HEW audit reports pertaining to the subject of settlements under the Medicare program. In addition, we interviewed officials of audit subcontractors at nine locations and officials of 43 hospitals to ascertain their views concerning the causes of delays in making final settlements.

Our review did not include an evaluation of the accuracy or reasonableness of individual settlements with hospitals and ECFs.

APPENDIXES

DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
WASHINGTON

OFFICE OF
THE SECRETARY

SEP 28 1970

Mr. Philip Charam
Associate Director, Civil Division
United States General Accounting Office
Washington, D. C. 20548

Dear Mr. Charam:

Enclosed are the Department's comments on your draft report entitled, "Lengthy Delays In Settling For The Costs of Medical Services Furnished Under The Medicare Programs." We have also enclosed a copy of the comments submitted by the Blue Cross Association.

We appreciate your contributions toward improving this aspect of Medicare administration.

Sincerely yours,

James B. Cardwell
Assistant Secretary, Comptroller

Enclosures

APPENDIX I

LENGTHY DELAYS IN SETTLING FOR
THE COSTS OF MEDICAL SERVICES
FURNISHED UNDER THE MEDICARE PROGRAM
(GAO Draft Report Transmitted June 30, 1970)

Our comments on the seven recommendations in GAO's draft audit report are as follows:

1. Recommendation: Establish a definite timetable for the development of an effective, useful, and timely provider reimbursement report or consider other alternatives, such as authorizing intermediaries to prepare the reports.

We continue to hold the view that SSA should prepare the Provider Statistical and Reimbursement (PS&R) Report because of the potential it has for us as a tool for administration and appraisal. In addition, there are economies to be obtained by producing it as a by-product of central data processing operations rather than separately by each intermediary. Rather than consider alternative possibilities, therefore, we have decided to concentrate on actions to overcome the problems that have so far hindered SSA in producing an effective, useful, and timely report. Most of these problems are associated with bill processing rather than the actual production of the provider charge data. For example, we are experiencing 60 day delays in receiving bills here at SSA. We expect to find solutions to these problems and are working to that end.

The principal actions that have been initiated, together with applicable timetables, are as follows:

a. A detailed study of the provider charge data developed by Minnesota Blue Cross is to be conducted, comparing this data on an item-by-item basis with the data for the same period on the PS&R Report. The purpose will be to identify the differences in the two reports and how they came about. To the extent that the study reveals any deficiencies in SSA's system for producing PS&R reports, we will determine what is needed to correct them. We aim to complete our study by November 1.

b. We expect to establish a daily update of the master record for Medicare beneficiaries in lieu of the present monthly update upon availability of new equipment. This means that as soon as discrepant items are corrected they will be posted to the beneficiary's record, rather than remaining on an orbit tape until the end of the month.

c. Two steps are being taken to reduce the number of bills in orbit. First, we expect to introduce shortly, hopefully

during November a new form to be used by providers to identify the discharge dates of beneficiaries whose benefits were previously exhausted. Secondly, we plan to issue within a month a revised Form SSA-1885 (Report of Interim Rate Changes), which will provide for the accurate identification of fiscal year ending dates and elicit prompt reporting of changes of ownership.

d. A model electronic data processing system, called the Part A Model System, is being introduced. This will substantially increase the number of intermediaries submitting billing data on magnetic tape and should cause a dramatic reduction of input errors. At the present time, we are experiencing about a 6 percent error rate on paper bills but only about 0.1 percent error on magnetic tape. In addition, magnetic tape billing permits update of records within 48 hours after receipt. This will greatly improve the currency of data available for presentation on the PS&R Report.

e. We are in the process of establishing controls over rejected bills, i.e., bills returned to intermediaries for correction. We believe those controls will speed up overall processing in that we will have a tool for assuring the prompt re-submission of bills by the intermediaries.

f. We are initiating a study at two or three intermediary locations of the bill batching and transmission processes to determine if processing time can be reduced. This study should be completed before February 1, 1971.

g. We are initiating a study of PS&R Reports for providers served by those intermediaries which have been submitting billing data on magnetic tape for a year or more. This should identify any problems we may have with capturing full information on a timely basis when data is received in this form.

2. Recommendation: Discontinue or modify the use of the combination method of apportioning costs between Medicare and non-Medicare patients.

As indicated in GAO's draft report, this recommendation reiterates proposals that have previously been made. Since the beginning of the Medicare program, SSA has been concerned with problems associated with use of the combination method. In addition, this matter received attention from the DHEW Audit Agency (AA) earlier this year. In an audit report issued in February 1970, AA questioned the value of continued use of the combination method.

Based on these earlier proposals, we have been giving intense study to the combination method as part of our complete re-examination of the whole area of Medicare cost reimbursement. We are charged with the responsibility of assuring that the best available approach is used to determine adequately the full reimbursable cost for services provided Medicare beneficiaries. To date, experience has not demonstrated that this can be accomplished with absolute precision under any method. Study has shown that we may achieve our objective by modifying the application of the combination method by restricting its use to certain types or sizes of facilities. We are in the process of reaching a decision in this matter. We will advise GAO when the final decision is made.

This recommendation does not deal with a simple problem in procurement; it involves complex issues of program policy and objectives. The audit recommendation is based mainly on the finding headlined in Chapter 3 of the report as "Elimination of Questionable Method of Apportioning Hospital Costs Would Reduce Medicare Payments By More Than $100 Million Annually." While we do not disagree with this finding, we do want to emphasize that, in itself, reducing or minimizing Medicare payments to hospitals is not a legitimate objective. This is not a situation where the Government is purchasing goods or services for its own use and can therefore apply the classical objective of obtaining the lowest possible price. Rather, we are reimbursing hospitals for services rendered to third parties under a Government insurance program. In this connection, our objective must be to carry out the mandate of the Congress that reimbursement be made under principles that "approximate as closely as practicable the actual cost (both direct and indirect) of services rendered to the beneficiaries of the program so that under any method of determining costs, the costs of services to individuals covered by the program will not be borne by individual's not covered, and the costs of services of individuals not covered will not be borne by the program" (House Report No. 213, 89th Congress, 1st Session, Page 32).

Thus, we continue to think modification of the combination method must be coordinated with other possible changes and considered in the context of the overall effect of the principles of reimbursement. The real issue is whether or not the overall rate of payment to hospitals is reasonable and whether the single departmental method of allocation would be fully satisfactory. We share the auditor's concern that inclusion of the combination method may cause the principles to tend toward excess reimbursement of hospitals. At the same time, we must be mindful of strong representations by the hospitals that other aspects of the existing principles have the opposite tendency. In the circumstances, a deliberate, considered and coordinated approach to modifying the principles best serves the objectives of the Medicare program.

3. Recommendation: Require intermediaries to provide increased onsite assistance to those hospitals which need help in adapting their accounting systems to meet Medicare cost reporting requirements.

We agree with the GAO findings that in the first years of Medicare operations unsophisticated and inadequate accounting systems were the cause of delays in the submittal of cost reports by hospitals. However, Medicare is now into its fifth year of actual operations. As discussed below, we believe that virtually all hospitals have now succeeded - with or without assistance - in establishing adequate cost accounting systems.

Our primary problem had not been one of having the hospitals adapt their existing accounting systems to Medicare reporting. Rather, we found that far too many had no cost accounting system at all.

When Medicare was first instituted, the ability of intermediaries to assist providers in establishing adequate accounting records was restricted by the pressures for getting the program operating and by limitations of their own personnel. Unfortunately, there is still a real problem in obtaining accounting personnel to do a fully adequate job in getting the provider audit/cost settlement process current. However, most intermediaries did make efforts to assist providers in establishing necessary accounting records. These were initially accomplished by conducting training sessions with the providers' administrative and accounting personnel. The sessions were subsequently followed up with individual provider visits during which more specific recommendations were made. Many intermediaries then followed up on the implementation of the recommendations through regular visits by their hospital relations staff.

Although some intermediaries did a far more effective job than others in this area, the major obstacle to accomplishing results was inaction by hospitals in actually setting up the record-keeping systems recommended. Early in the program we received indications that some intermediaries may have offered hospitals actual management and accounting services rather than just advice and assistance. Further, a number of hospitals were asking for 100 percent reimbursement for the costs of renovating their recordkeeping systems to accomodate Medicare's cost accounting needs rather than apportioning these costs to all "lines of business" as a general and administrative expense. We denied requests of this type.

When the first round of hospital audits was conducted, it was found that many hospitals had not implemented the necessary cost accounting systems and recommendations. Consequently, a by-product of the first round of audits was the establishment of necessary record-keeping systems. Presently, about 2/3 of the hospitals have undergone their second audit. As conformity with Medicare's cost accounting needs is necessary for a proper audit to be conducted, the audits point out inadequacies in the hospital's cost accounting systems.

Intermediaries continue to conduct group training sessions as program needs change. Also, they are rendering onsite assistance where regular visits by

their hospital relations staff indicate it is needed. SSA supports and encourages these activities.

4. Recommendation: Attempt to persuade hospitals to adopt different cost-reporting periods to provide more even distribution of intermediary workloads and to facilitate preparation and/or audits of cost reports by accounting firms.

We do not feel that it is practical for the Administration to require or even indirectly urge providers to change their cost reporting periods purely for the purpose of distributing intermediary workloads. We are actively exploring what we feel to be a more realistic approach to improving the workload situation. We are considering changes in regulations to require that provider cost reports cover the same operating period covered by the providers' annual report to IRS. Providers which do not report annually to IRS will continue to prepare and submit their cost reports under present procedures.

This new procedure will provide a three fold benefit in the preparation of cost reports. First, as the report will be made in conjunction with the IRS report, it will make the provider's job easier. Since the provider will be able to prepare his Medicare cost report from the same audit used for tax return purposes, we believe that the timely filing of cost reports will be encouraged. Secondly, and more closely related to the recommendation, implementation of this procedure will make more cost reports available for audit at a time when audit firms and accountants would be more available; that is, after the "tax season." This will improve handling of those cases requiring audits by making more manpower available at the point where we have the greatest workload. Thirdly, this procedure will more evenly distribute cost report due dates. If these reports are filed timely, a better distribution of workloads will be realized.

We should note here that even if conformity with IRS' reporting period may not change a provider's year ending date, it will affect the provider's reporting date. IRS allows varying reporting periods after the year ending dates based on type of business.

The following chart, using a December 31, 1969 year end for both Medicare and IRS, illustrates how the proposed policy would operate and how it compares with present program policy:

Provider Form of Organization	IRS Date	Due Date of Medicare Cost Report	
		Proposed Policy	Present Policy
Voluntary nonprofit	05/15	05/15	03/31
Proprietary			
Sole proprietor	04/15	04/15	03/31
Partnership	04/15	04/15	03/31
Corporation	03/15	03/15	03/31
Fiduciary	04/15	04/15	03/31
Governmental	-----	03/31	03/31

As the change will extend the reporting period for many providers, this will give them more flexibility in getting accountant time for cost report preparation. We have reason to believe that the bulk of the private non-profit hospitals are concentrated in the periods of heaviest workload. As most of the ECF's are proprietary, they are more likely to operate on a fiscal year basis and profit from conformity to IRS' reporting periods.

In addition, CAO's concern with the shortage of auditors is no longer serious. Our recent adoption of the periodic audit program has vastly altered the situation. We have reduced by two thirds the number of audited cost reports required. We are now faced with a surplus of auditor's time.

While our proposals are in the early stages of consideration, we are hopeful that we will be able to move rapidly in this area.

5. Recommendation: Require the Blue Cross Association to render more assistance to individual Blue Cross Plans in obtaining and training staff needed for making desk reviews of provider cost reports.

SSA concurs in this recommendation. As noted in their response, BCA has already initiated actions to accomplish this objective and has had considerable success in strengthening the desk review process in individual Plans. The fiscal year 1971 budget provides over thirteen and a half million dollars to Blue Cross Plans for in-house staff for desk reviews and field audits.

SSA is closely monitoring intermediaries' provider reimbursement and audit activity, with particular emphasis on assuring that intermediaries have sufficient trained in-house staff to perform desk reviews. In November 1969 SSA instituted a formal system of in-depth reviews of the reimbursement and audit area by Bureau of Health Insurance (BHI) regional offices. These reviews have been very effective.

6. Recommendation: Require BCA to take a more active role in making final settlements with providers at those local Blue Cross Plans where backlogs of audited but unsettled cost reports are most serious.

BCA's role in both its Medicare and non-Medicare relations with the Plans is not an operating one; it is essentially administrative. Consequently BCA does not have sufficient staff to become directly involved in individual provider cost settlements. BCA has, however, consulted with and assisted Plans in improving their performance in this area. Further, since the preparation by the provider of the adjusted cost report reflecting audit exceptions is one of the major causes of delay in accomplishing settlements, BCA took the initiative in instructing Plans to prepare the adjusted cost report for providers where the lack of such action by the provider was delaying settlement. In addition, BCA assisted in developing the short cut adjustment form which further facilitates the settlement process.

A new instruction (Intermediary Letter 70-29 dated August 1970) has been issued providing for settling more cost reports without audits. As a result, the backlog of unsettled cost reports will be further reduced.

Because of the critical need to get current on the provider audit-cost settlement process, SSA, in November 1969, established a formal system of in-depth regional office reviews of intermediary audit-settlement operations to assure that, among other things, the intermediaries had sufficient staff and administrative controls to make prompt settlement after completion of audit. These activities of our regional staff have proved productive, and we now see improvement in the performance of several Plans whose settlement process had previously lagged badly. We will continue working through BCA and our regional offices, and particularly with our onsite representatives, to improve the settlement process for all providers.

7. Recommendation: Increase its effort to encourage intermediaries to develop as a minimum the capability for making limited scope field audits of provider cost reports. [See GAO note 1.]

All intermediaries are now performing desk reviews with in-house staff. Over 40 of the Blue Cross Plans and half of the commercial insurance companies now conduct some field audits with their own staff. Reports we receive from intermediaries on audit activity show substantially increased use of the limited scope approach. The following information was taken from the June report of Provider Audit Activity and is indicative of progress in the past several months:

HOSPITALS - Cumulative data through June 30, 1970

Cost reporting period	1st yr.	2nd yr.	3rd yr.	4th yr.
No. Fields Audits Completed	6,138	5,343	3,070	368
% of Limited Scope Audits Performed	1.61	15.91	42.90	54.35

The increased proportion of limited scope audits for subsequent reporting periods is what we had expected. It is attributable to the improvement in provider recordkeeping systems as a result of the audits of earlier periods and to the accumulation by intermediaries of a data base of provider cost experience. The increased use of the limited scope audit approach by intermediaries is also indicative of the effectiveness of the in-depth regional office reviews of intermediary audit activities initiated in November 1969. As mentioned above, we recently gave renewed emphasis to the no audit/limited scope audit approach through Issuance of Intermediary Letter 70-29 dated August 1970.

[See GAO note 2.]

GAO note

1. This recommendation was not made in the final report. (See p. 70.)

2. The deleted material pertains to suggested changes or to certain updated statistical data which have been incorporated into the report.

BERNARD [illegible] OWSKI
Senior Vice President
Government Programs

BLUE CROSS ASSOCIATION

840 NORTH LAKE SHORE DRIVE • CHICAGO, ILLINOIS 60611 • (312) 329-8029

July 14, 1970

Mr. James L. Calhoon
Deputy Assistant Bureau Director
Bureau of Health Insurance
Division of Intermediary Operations
Social Security Administration
Baltimore, Maryland 21235

Dear Jim:

We received your letter on July 9, 1970, enclosing a copy of the draft report from the General Accounting Office on their study conducted on delays in making final settlement under the Medicare Program. The deadline for submission of comments by July 15, 1970, did not give us adequate time to review the report in detail. We would welcome an opportunity to visit with the representatives from the General Accounting Office to go over the report in greater detail. We would also appreciate receiving a copy of your reply to the General Accounting Office concerning the matters contained in the draft report.

In the limited time available to review the report, we would at this time limit our comments to the following reactions to the recommendations contained on pages 68 and 69.

1. We support and underscore the concern expressed by the General Accounting Office that "Medicare payments have not been afforded a proper final accounting". This concern takes on added importance when viewed within the framework of the extremely restricted audit budget available for fiscal year 1971.

Serving the Nation

2. We support the GAO recommendation that Intermediaries provide increased onsite assistance to hospitals in meeting Medicare cost reporting requirements. As you know, SSA established very restrictive guidelines concerning the allowable time available to the Intermediary in working with providers of care in this regard.

3. We support the recommendation that BCA extend its assistance to Blue Cross Plans in obtaining and training staff needed for the provider audit activities. BCA operates an extensive search and transfer program through our Human Resources Division. Extensive recruiting has been conducted by the Blue Cross Association outside the United States and has been most successful in attracting qualified accountants for positions in Blue Cross Plans in the United States. Noteworthy in this regard is the staff of the Chicago Blue Cross Plan largely recruited in England.

4. The recommendation that BCA take a more active role in making final settlements with providers at those Plans with significant backlogs should be viewed in the context of the series of significant steps taken by BCA during 1969 to resolve audit backlogs. Included in this action was:

   (a) direction to the Plans concerning penalties to be applied for non-receipt of cost reports,

   (b) authority for the Plan to sign off a cost report on an appeal basis,

   (c) development of a short-cut adjustment form,

   (d) development and auditing of Government provider cost reports, and

   (e) program for handling medical school and teaching hospital cost reports.

5. The recommendation to increase the capability for making limited scope field audits of provider cost reports should be viewed in the context of the issuance of BCA Administrative Bulletin No. 225 on August 4, 1969, concerning a limited audit scope program. This program was followed up by a series of regional meetings during the months of October and November of 1969.

Thank you for sharing this report with us. We would again urge an opportunity to visit with representatives of the General Accounting Office to review their report in greater detail. [See GAO note]

Very truly yours,

Bernard R. Tresnowski

BRT:moa
cc: Robert Ouloosian
James L. Harford

GAO note: GAO representatives met with BCA officials who suggested several language changes and other revisions which have been incorporated into the body of the report.

APPENDIX III

PRINCIPAL OFFICIALS OF THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE RESPONSIBLE FOR ADMINISTRATION OF THE ACTIVITIES DISCUSSED IN THIS REPORT

	Tenure of office	
	From	To
SECRETARY OF HEALTH, EDUCATION, AND WELFARE:		
Elliot L. Richardson	June 1970	Present
Robert H. Finch	Jan. 1969	June 1970
Wilbur J. Cohen	Mar. 1968	Jan. 1969
John W. Gardner	Aug. 1965	Mar. 1968
COMMISSIONER OF SOCIAL SECURITY:		
Robert M. Ball	Apr. 1962	Present
DIRECTOR, BUREAU OF HEALTH INSURANCE (note a):		
Thomas M. Tierney	Apr. 1967	Present
Arthur E. Hess	July 1965	Apr. 1967

[a]The Bureau of Health Insurance was a part of the Bureau of Disability and Health Insurance until September 1965. At that time separate bureaus were established to handle the functions of the disability program and the health insurance program.

U.S. GAO, Wash., D.C.